What Globalization does to People's Health !

Towards the People's Health Assembly Book—1

What Globalisation does to Peoples Health !

-Understanding what Globalisation is all about and how it affects the health of the poor

Prepared and Published by
The National Coordination Committee
for the

Jan Swasthya Sabha

Towards the People's Health Assembly Book-1

What Globalisation does to Peoples Health!

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- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- All India Women's Conference (AIWC)
- Bharat Gyan Vigyan Samithi (BGVS)
- Catholic Health Association of India (CHAI)
- Christian Medical Association of India (CMAI)
- Forum for Creche & Child Care Services (FORCES)
- Federation of Medical Representatives Associations of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Society for Community Health Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

Participating Organizations

Over 1000 organizations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Sabha campaign as participating organizations.

About the Jan Swasthya Sabha

Governments & international agencies have forgotten the goal of **Health for All by 2000 A.D.** But we, the people, cannot forget it. It is time to strengthen & expand people centered initiatives - to find innovative solutions & to put pressure on decision makers, governments and the private sector.

There is a need to reiterate that attaining **Health for All** means ensuring everyone has access to affordable quality medicare, safe drinking water and sanitation, adequate nutrition, clothing, shelter and employment and no one is discriminated against on the basis of class, caste, race or gender. People need to be made aware of the links between globalization and the worsening health of the people. When structural adjustment policies work to undermine the vision of Alma Ata, renewing the Health for All call is an imperative.

With this understanding a large number of people's movements across the country have jointly initiated a national campaign called the Jan Swasthya Sabha. This has three broad objectives:

- ☞ To re-establish health and equitable development as top priorities in policy making with primary health care as the strategy.
- ☞ To forge a local, national and global unity of all democratic forces to work towards building long term sustainable solutions to health.
- ☞ Reinforce the principle of health as a broad inter-sectoral issue

The campaign has a four-tier structure. 2000-3000 blocks in 200-300 districts mobilize people on **Health For ALL – Now!** and conduct block level enquiries into the state of health services. These enquiries culminate in block seminars highlighting the findings & helping formulate people's initiatives for primary health care. Then, each district has a district level mobilization culminating in a District Seminar. All this builds up to the Jan Swasthya Sabha to be held in Calcutta from Nov 30th – Dec 1st 2000. Four trains with representatives from various parts of the country will arrive at the National Assembly. The Jan Swathya Sabha – with over 2000 representatives – will call for a reversal of structural adjustment policies and a renewal of the *Health for All* pledge. The assembly will also send its representatives to the international People's Health Assembly being held at Dhaka from Dec 4th-8th, 2000 where similar representatives from other countries will gather. Following the Jan Swasthya Sabha, each interested block or district follows up with health intervention and advocacy.

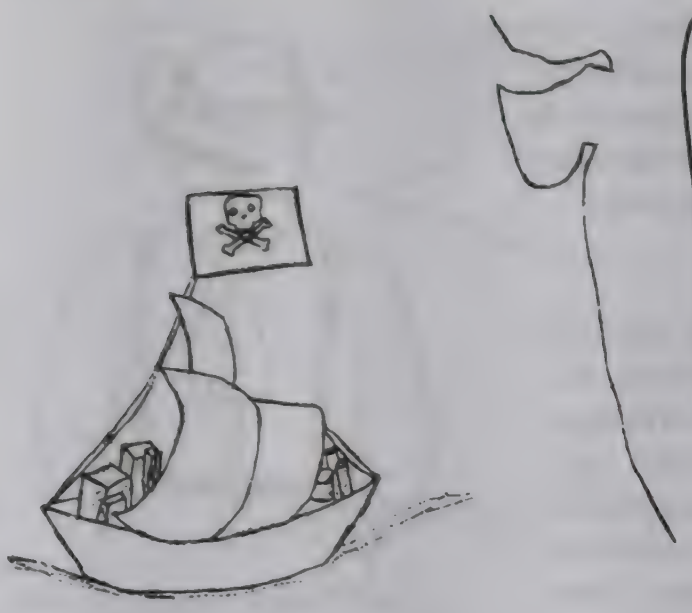
The Jan Swasthya Sabha is being coordinated by a National Coordination Committee consisting of 18 major all India networks of peoples movements and NGOs. This book is the One book in a 5 book series brought out by the NCC for guiding the block, district and state seminars.

Contents

Chapter 1	:	Globalisation and People's Health-An Overview	1
Chapter 2	:	Understanding the Jargon	24
Chapter 3	:	The Financing of Health Care	27
Chapter 4	:	Globalisation and Pharmaceuticals.	36
Chapter 5	:	Globalisation and Food Security	43
Annexure	:	The alma ata declaration.	52

Chapter I

Globalization and People's Health



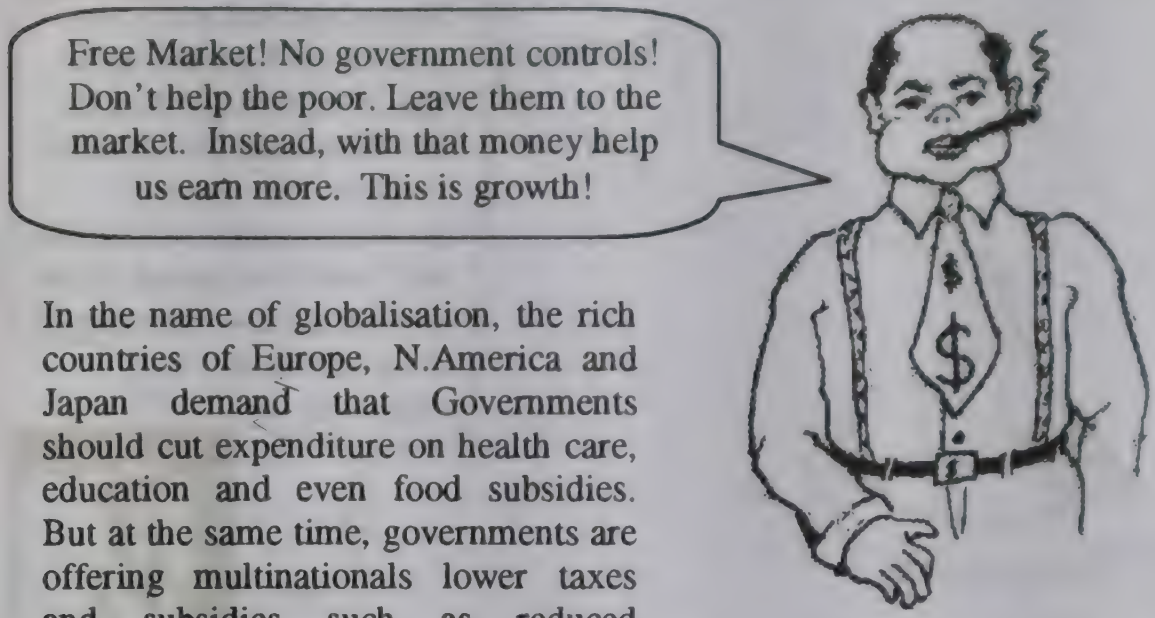
Many hundred years ago, there lived a pirate on the shores of Europe. And he set out to find the sea-route to India. The world's greatest tragedy was that he did! And that started off the western nations' plunder of Asia, Africa and the Americas.

The colonizing enterprise did not really happen because one Vasco da Gama found a route to India! It was the result of large-scale economic changes happening in Europe. Capitalism (also known as greed) was the driving force behind the search for the sea-route and behind colonization.

The British colonised India 250 years ago. The motivation of the western countries was beyond doubt greed. The capitalist "free market economy" has, even by its own stated understanding, only one goal – profit. This colonial loot was helped by the Industrial Revolution (development of machine based production), which began in Britain about 250 years ago. The new factories produced steamships and guns that made conquest unequal, easy and bloody.

Today we hear the term 'globalisation' being used to describe the expansion of the global capitalist economy. In India, Pepsi, Coca-Cola, Western TV shows and movies, and foreign clothes like Nike, are common. India is opening up even more to the global market economy. But the history of the last 500 years shows us that globalisation is just another word for the continuation of that form of capitalist exploitation that is known as imperialism. Globalisation is a word that has been deliberately coined to raise false hopes among the poor of the world, that

the current processes in the global economy will allow them to approach the standards enjoyed by the rich in the countries of North America, Europe and Japan. While selling this false dream, these countries have mounted a fresh offensive to predate upon the resources of poor countries.



In the name of globalisation, the rich countries of Europe, N.America and Japan demand that Governments should cut expenditure on health care, education and even food subsidies. But at the same time, governments are offering multinationals lower taxes and subsidies such as reduced electricity rates. The "free" market economy is not free at all -- it is controlled to benefit only the rich at the cost of the poor.

Inequalities between countries have increased and the past decade has shown increasing concentration of income, resources and wealth among people, corporations and countries. The income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest was 74 to 1 in 1997, up from 60 to 1 in 1990 and 30 to 1 in 1960. In 1996, the working class of the world received an average 3% increase in wages while the heads of multinational corporations received a 67% increase. The 5 largest multinationals, mostly American, together earn more in one year than all of the domestic earnings together of India, Pakistan, and Bangladesh.

By the late 1990s

The top fifth (20%) of the world's people have	The bottom fifth (20%) of the world's people have
86% of world GDP	Just 1% of world GDP
82% of world exports markets	Just 1%
68% of foreign direct investment	Only 1%
74% of world's telephone lines	Only 1.5%

Thus, the concept of globalization has justified with ease a set of unequal relationship among peoples and nations.

But how did this process of globalization begin?

The Genesis of Globalisation

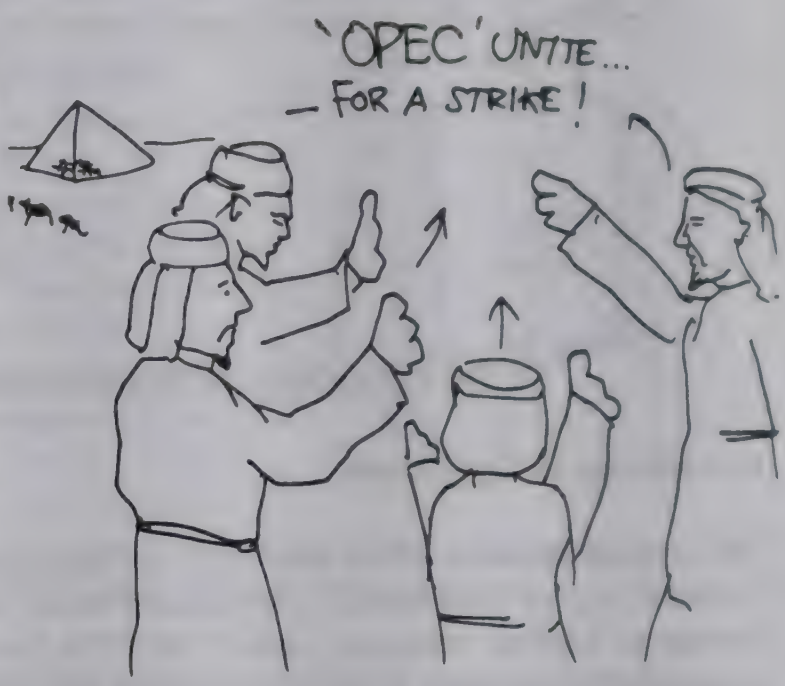
Golden Age of Capitalism

The period between 1945 and 1970 is frequently referred to as the 'Golden Age of Capitalism'. The second world war had seen the USA emerge as a strong industrial power. The USA helped to rehabilitate and restore the economies of Western Europe and Japan. It also helped to kick-start the industrialization of East and South East Asia (S.Korea, Taiwan, Singapore, etc.) -- as a bulwark against the spread of Socialism. During this period a large number of countries, like India, were liberated from hundreds of years of colonial rule. Many of these countries embarked on a path of rapid industrialisation, and saw significant progress in socio-economic spheres of development. In this, they benefited significantly from help that they received from the then Soviet Union and Socialist countries in

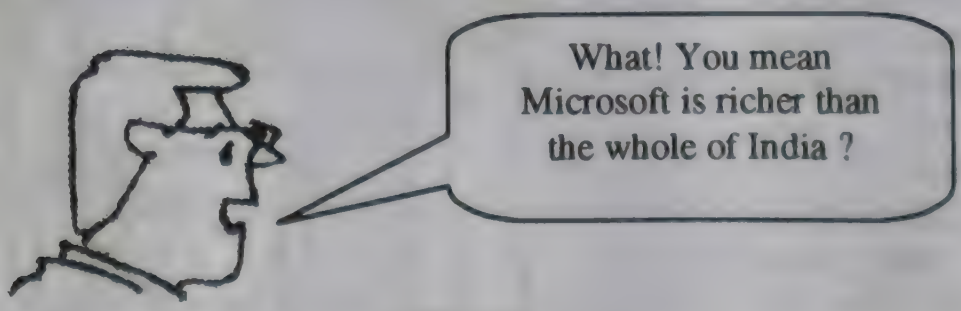
Eastern Europe. The interference in the development processes in these countries, by the Capitalist countries of Europe, N.America and Japan was relatively subdued.

Crisis in Developed Countries and Capital Accumulation

The Golden Age of Capitalism faltered in the seventies, following the shock of the sudden (and precipitate) oil price hike by the OPEC (oil producing countries, located mainly in the Middle East) in Nov. 1973. There followed a long period of crisis in all the developed countries (other than Japan, where the slump commenced from the early nineties), characterized by a slump in economic activity.

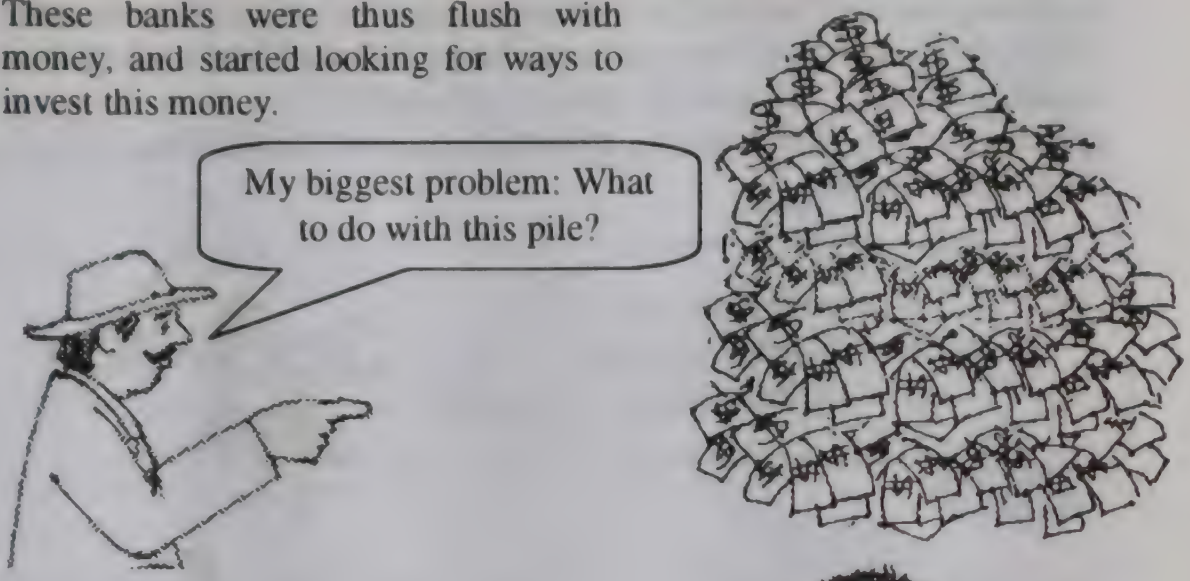


Alongside this, another new phenomenon emerged. There began an accumulation of money (or Capital - as economists call it) on an unprecedented scale in a few hands. A major source of this accumulation was due to the growing resources and influence of Multi National Corporations (MNCs). Their growth has been so phenomenal that several of them are bigger that the economies of entire nations. For example the sales of General Motors (164 Billion US$) is more than the GDP of Thailand (154 Billion $) and Norway (153 Billion $). The market value of Microsoft touched $507 billion, about Rs 21,92,267 crore - a value that is much higher than India's Gross Domestic Product (GDP) of about Rs. 17,70,000 Crores.

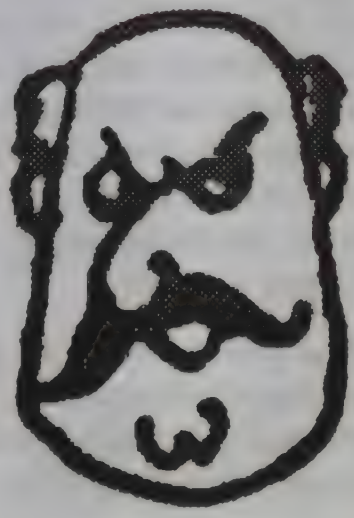


Over the years MNCs have grown larger and stronger through mergers amongst themselves, and acquisition of smaller companies across the globe.

Another source of accumulation was the huge profits made by oil producing countries, which they deposited into western capitalist banks. These banks were thus flush with money, and started looking for ways to invest this money.



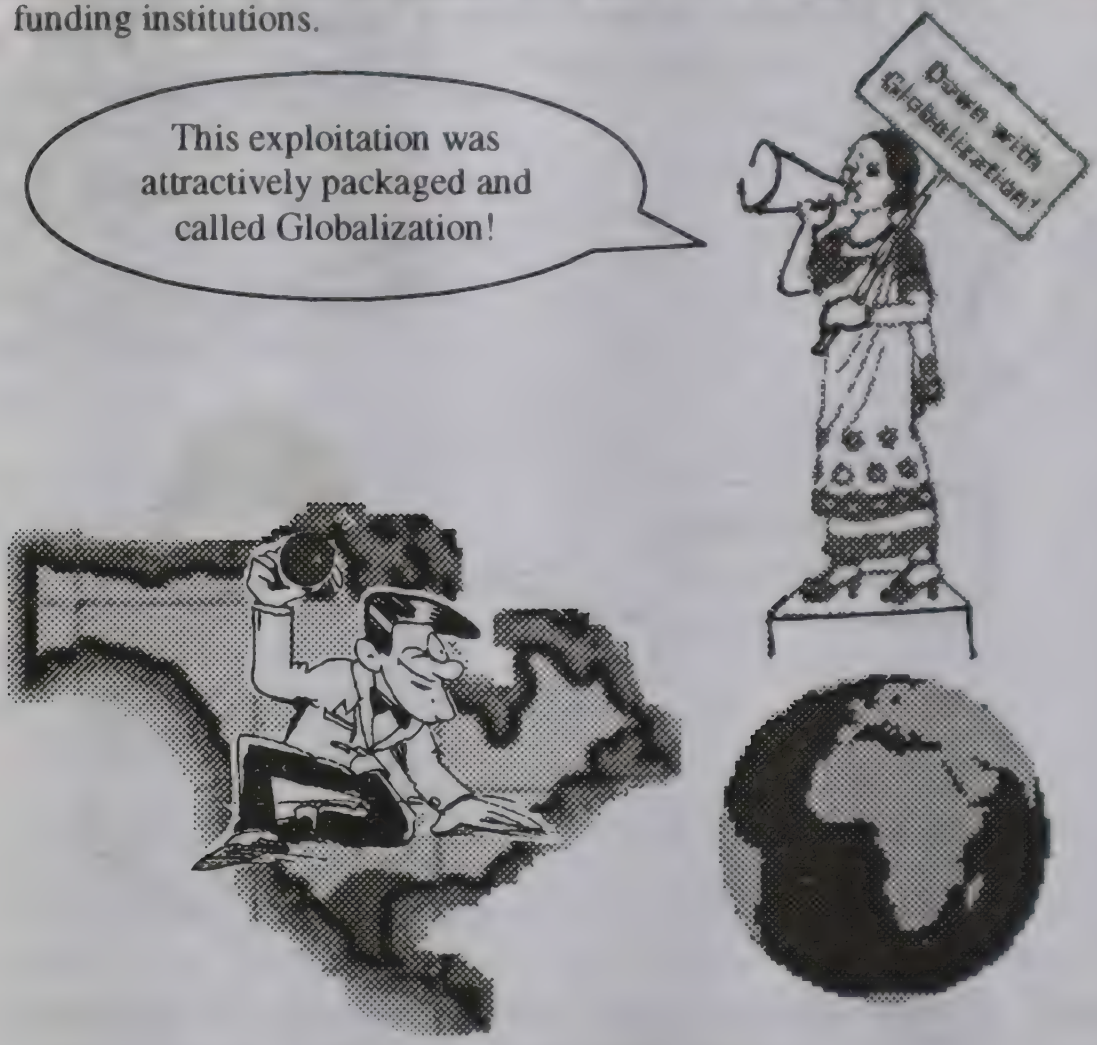
Finally, a third source of capital accumulation was the increasing volumes of illicit or illegal incomes from crimes of various kinds - ranging from drug smuggling and drug peddling to the plunder (by dictatorial rulers and others from the ruling elite) of the wealth of developing countries. Dictators like Marcos and Mobutu siphoned off large funds from otherwise poor countries. And respectable bankers of developed countries sweetly "laundered" all such ill-gotten gains.



Real Face of Globalization

Thus, the availability of "surplus" money in the global economy became enormous, and it came at a stage when the economies of the developed countries were facing a slump and were incapable of absorbing this money in production related activities. This produced the impetus for the process of

globalization, where avenues were sought, on one hand by MNCs to sell their products in developing countries, and on the other by capitalist banks to push their money (in the form of loans) in developing countries. If both these objectives were to be met the economies of the developing countries had to be prised open -- to allow free flow of goods manufactured by MNCs and to allow free flow of Capital from Western funding institutions.



The Numero Uno Globe Bomber

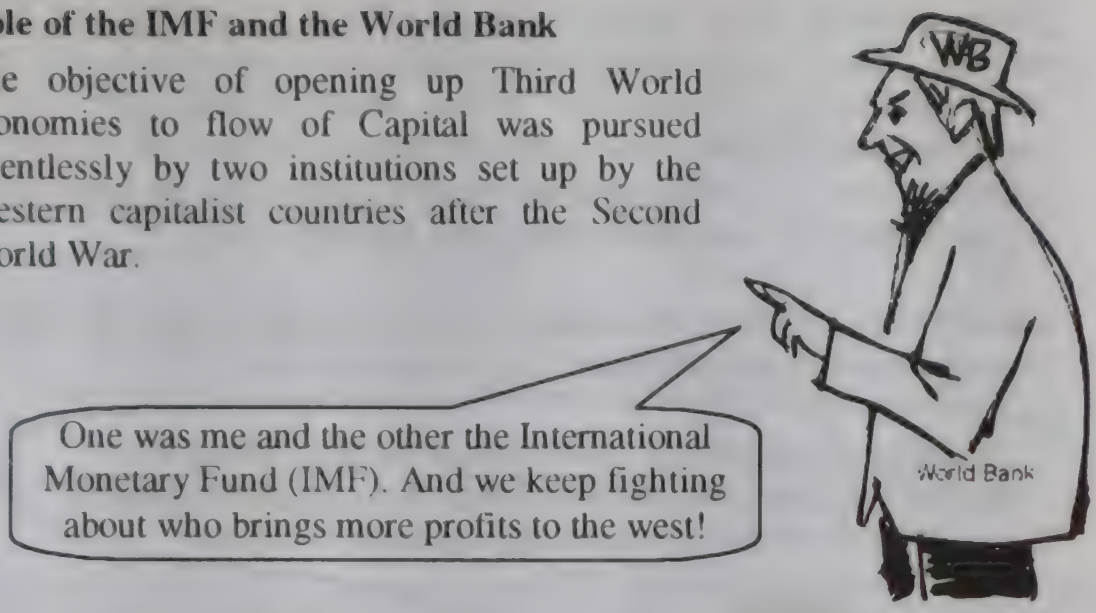
Essentially it meant that the economies of developing countries were forced to open their markets to MNCs and their economies to free flow of Capital from Western institutions.

One glaring effect of globalization has been the explosive growth of MNCs across national borders. Capitalism identifies nations not as nations but as 'markets' and countries like India and China are the vast, untapped markets. 2 billion unshod feet is a tantalizing opportunity for Bata, Nike, Reebok and their ilk. Even if only 10% of these can afford shoes, this means a 200 million person market which as large as all of Western Europe!

As a global slump in productive activities creeps across the world, developed countries seek to expand their markets beyond their own boundaries and the obvious targets are nations such as India. Never mind that the majority in these countries can barely make ends meet.

Role of the IMF and the World Bank

The objective of opening up Third World economies to flow of Capital was pursued relentlessly by two institutions set up by the Western capitalist countries after the Second World War.



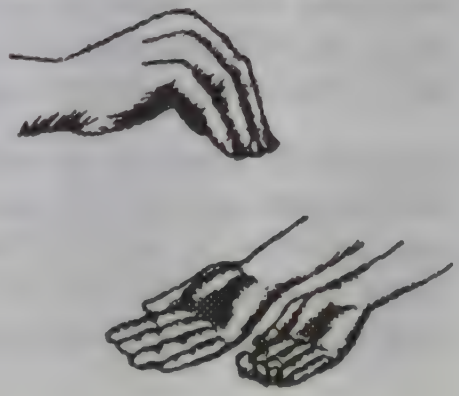
And that while they claimed their goal was to aid development! They directly control billions of dollars each year and indirectly even more.

The World Bank and the IMF

For the last 50 years the IMF & the WB have had unchecked decision-making powers over managing the "Third World" debt. They have secured guaranteed flows of reserves from the South to the North. Since 1947 the WB has made profit every year. Between 1980 & 1992 its net earnings rose over 172% to over $1.6 billion. The accumulated retained earnings of the WB alone amount to over $14 billion.

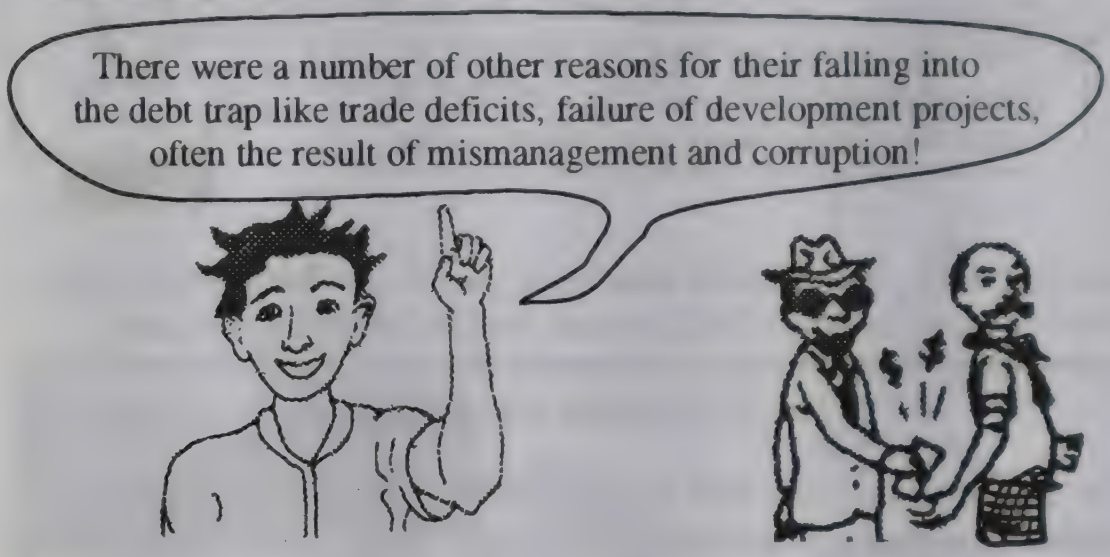
Both the IMF & WB are structurally undemocratic. Voting power does not operate on one vote one country but is determined by the amount of money invested by each member country. While more than 150 countries are members of the IMF five of them (USA, Britain, Germany, France, Japan & Saudi Arabia) control 44% of the votes. The USA alone controls 19% of the vote. In the case of the WB, the 24 OECD countries control more than two thirds of the votes. Clearly this gives the rich countries a great deal of power.

Third World countries had been hit hard by the hike in oil prices in 1973. Further, in the 1970s developing countries faced increased economic problems as a result of unfair trade. Their economies were designed around the export of raw materials and agricultural products, the price of which was manipulated on the world market by developed countries. Over the last few decades the price of these commodities have declined sharply while the import of manufactured

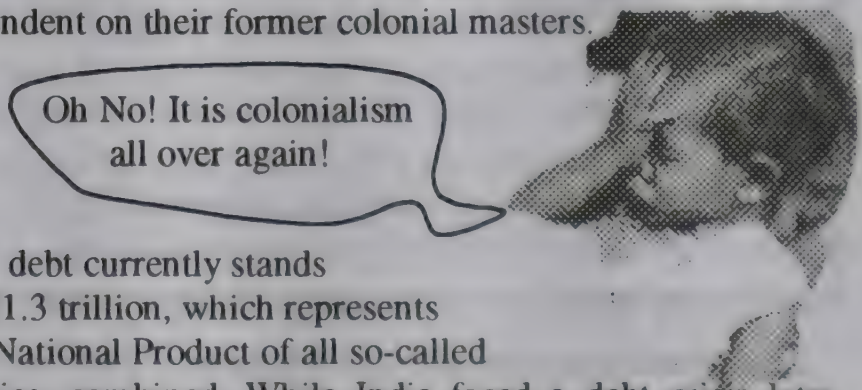


goods produced in the highly industrial countries has increased. Faced with the twin crisis the developing countries were eager to borrow more and more money from western banks, which, in turn, were only too happy to lend out more money and earn interest on their oil money. The crisis hit when the global economy slumped further and the interest rates for the money that was lent was hiked in the early 1980s.

Third World countries now found it very difficult to keep up with the interest payments and fell deeper and deeper into debt.



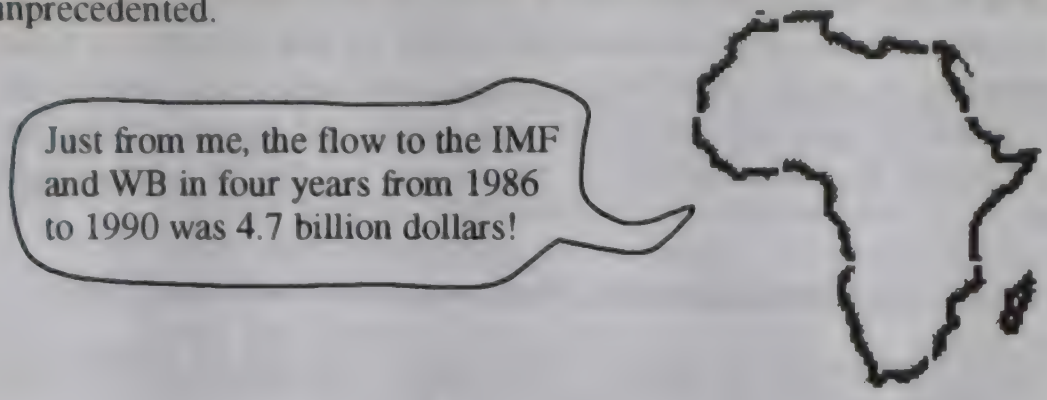
Further loans were given to "help" create conditions for the repayment of loans, and in the process creating a vicious debt trap, i.e. a situation when poor countries have to spend a very higher percentage of the national product just to pay the interests on the loans taken. Third World countries had achieved political independence but they were now in debt to the big western "moneylenders" and were, therefore, more and more economically dependent on their former colonial masters.



The '*Third World*' debt currently stands at approximately $1.3 trillion, which represents 44% of the Gross National Product of all so-called developing countries, combined. While India faced a debt crisis later than many other countries, in the late 1980s and 1990s, India today owes almost Rs. 400 thousand crore to the World Bank, IMF and other foreign banks. This is Rs. 4,000 for each man, woman and child in India.

The ultimate result of the massive loans given by institutions like the World Bank and the IMF has been a massive loss of capital from the poor countries to the rich countries in the North - an estimated $50 billion in 1985 alone. In 1990 there was a net transfer of $156 billion from the "third world" to the developed countries. In other words, what

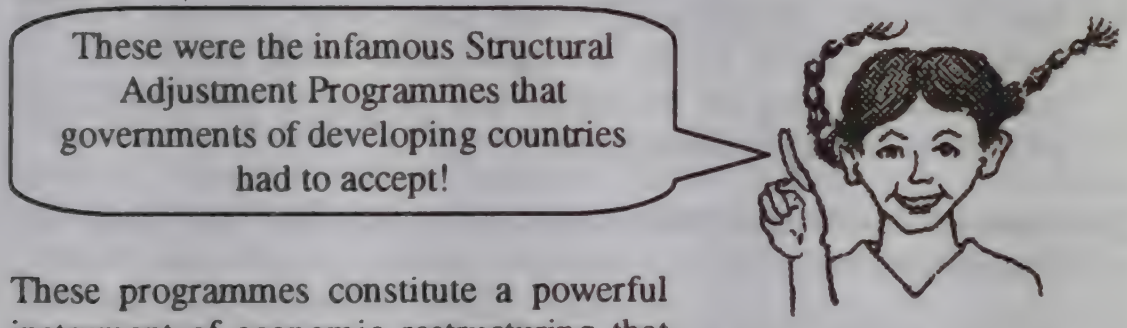
is happening is, as a result of the lending by the WB and the IMF, and the requirement to repay with interest, there is a reverse flow from the developing countries to the developed countries, on a scale, which is unprecedented.



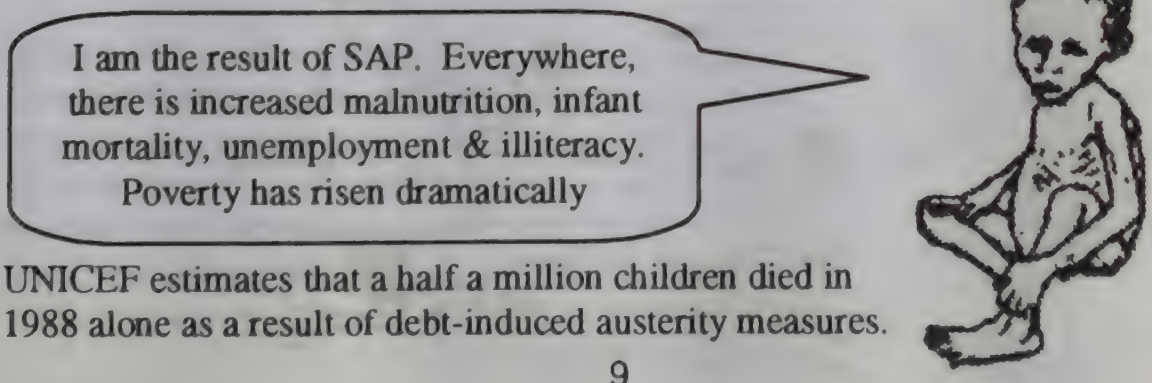
Thus, the developed countries have been able to transfer the crisis of their own economies on to those of poor developing countries.

Structural Adjustment Programmes (SAPs)

The story does not stop here. In the face of the debt crisis banks and other financial institutions saw the need to safeguard their own interests, i.e. to ensure that they get back the money that they had lent to the developing countries. They developed tough conditions on loans to "Third World" countries to ensure that there would be no defaulting on their debt repayments. Stringent conditions were imposed on further loans.



These programmes constitute a powerful instrument of economic restructuring that affects the livelihood of millions of people. The same prescription of reduced government spending – especially on social sectors, trade liberalization and privatization was applied simultaneously in more than 70 indebted countries.



UNICEF estimates that a half a million children died in 1988 alone as a result of debt-induced austerity measures.

The application of SAPs in a large number of indebted countries favours the globalization of economic policy under the direct control of the IMF and WB acting on behalf of powerful financial and political interests in the developed countries. Governments which do not conform to these programmes are black-listed. When a country is black-listed, investment and technology transfers are frozen and export and import credits are often blocked thus encroaching on the normal conduct of international trade.

In brief, the Structural Adjustment Programme (SAP) was designed to:

1. **Cut government spending** -- this means big cuts in health care, education and subsidies to farmers and the poor.

2. **Privatize** -- state owned industries and services must be sold off to private corporations. Often foreign multinationals are the buyers. Many workers lose their jobs as government industries close down. Services like transportation and power become more expensive.

3. **Devalue the local currency** - for example, in India the rupee should be worth less and less compared to the American dollar. The World Bank and IMF demand this so that what the country exports is cheaper in the international market. The World Bank and IMF say this will increase the country's exports so it can earn foreign dollars - and pay back the loans! But farmers and local industries get less for their goods. And prices of imports go up!

4. **Export more** - the country should export more to earn foreign dollars to pay back loans. The agricultural sector should turn to commercial farming for the market and for export, rather than food production for local consumption.

5. **Open up**: to foreign multinational companies like Pepsi, Shell Oil, Nike, Nestle, etc.

6. **Reduce duties and tariffs on imports** - in this way foreign multinationals can more easily sell their products in a country like India. Local industries find it hard to compete with cheaper imports.

Specifically, in the Health Sector it meant:

i. A cut in the welfare investment, leading to gradual dismantling of the public health services.

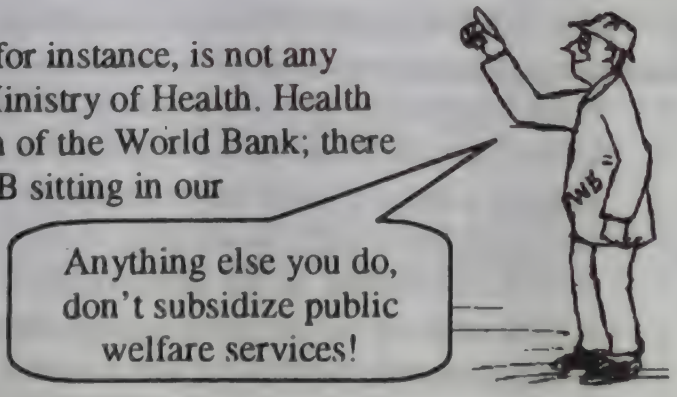
ii. Introduction of service charges in public institutions, which has now making the services inaccessible to the poor.

iii. Handing over the responsibility of health service to the private sector and undermining the rationality of public health. The private sector on the other hand focused only on curative care. India for instance, was forced to reduce its public health expenditure in health and to recover the cost of health services from its users by international banks.

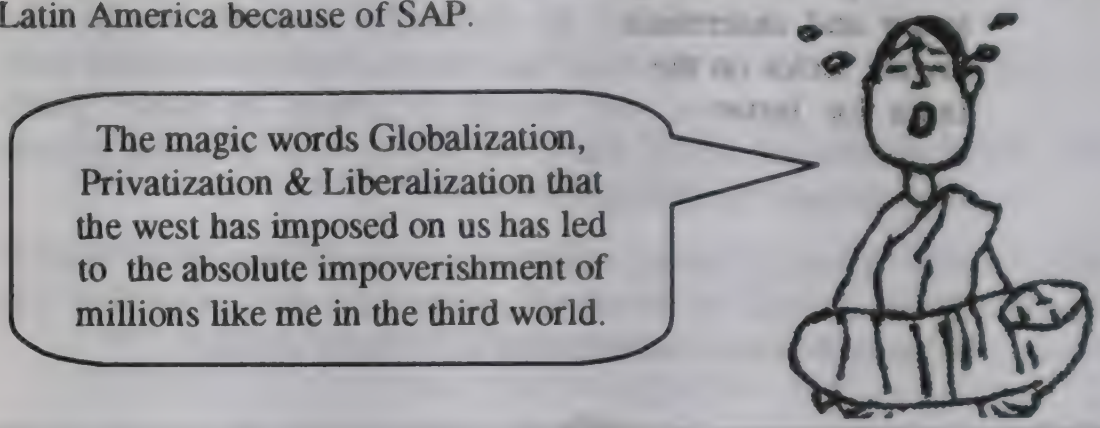
iv. The voluntary sector, which has also stepped in to provide health services is forced to **concentrate and prioritize** only those areas where international aid is made available.

SAPs were initiated in many countries in Latin America and Africa in the 1970s. Recorded information proves that SAP has been detrimental to nation states in that region. In spite of this experience, the same prescriptions were applied to nations such as India and the result have been predictable: rising prices, inflation, rising unemployment, change in cropping patterns, loss of food security, withdrawal of subsidies on public welfare services such as public health, education and the public distribution system. These have directly and selectively affected the already 'disadvantaged' in our country. Combined with this is the larger issue of loss of sovereignty since our Parliament can no longer make policies favoring our people but is bound by conditions agreed to and dictated by the WB/IMF.

Health policy formulation, for instance, is not any more in the hands of our Ministry of Health. Health policies are now the domain of the World Bank; there is a representative of the WB sitting in our Ministry of Finance telling us how we should allocate funds.



The impact of SAP on the third world is manifold. In seven African countries the infant mortality rate, which previously declined, increased from 4% to 54%. A steep increase from 3.1% to 90.9% of mortality rates of children under 5 years was observed. The nutritional status of children has deteriorated in around 8 countries out of the 10, which went through SAP. It has also been estimated that at least six million children under five years of age have died each year since 1982 in Africa, Asia and Latin America because of SAP.



The number of people living in poverty continues to grow as globalization proceeds along its inherently asymmetrical course: expanding markets across national boundaries and increasing the incomes of a relative few while further strangling the lives of those without the resources to be investors or the capabilities to benefit from the global culture. The majority are women and children, poor before, but even more so now, as the two-tiered world economy widens the gaps between rich and poor countries and between rich & poor people.

- The State of the World's Children 2000

The Marginalized in the Present Scenario

The policies have been disastrous for the third world and more so for the poor in the third world. After SAP, mal-distribution of global income has attained unacceptable levels. During the period 1960-70 the poorest 20% received 2.3% of the global income. In 1990, they received a minute 1.3% of the global income, a reduction by half. Meanwhile, the richest 20% of people in the highest income countries account for 86% of the total private consumption expenditures. While consumption has steadily increased in the industrial countries by about 2.3% annually over the past 25 years, the worlds poorest 20% live outside the consumption market!

- Over a billion people are deprived of basic consumption needs
- 60% of people in developing countries don't have basic sanitation
- Almost a third of them have no access to clean water
- A quarter exist with no adequate housing
- A fifth of children do not attend school to grade 5.
- A fifth of them do not have enough dietary energy or protein
- 2 billion people worldwide are anaemic.

Table 1
Percent share of the poorest 20% of the World Population in Global Opportunity

	% of Global Economic Activity	
	1960-70	1990
Global GNP	2.3	1.3
Global trade	1.3	0.9
Global domestic investment	3.5	1.1
Global domestic savings	3.5	0.9
Global commercial credit	0.3	0.2

Source: Human Development Report 1993

It is very clear that the poor are increasing and more so after the intervention of international financial institutions. The distribution of the world's poor showing their concentration in the developing nations is given in the following table:

Table 2
Distribution of the World's poor 1985-90

Region	Number of poor in millions	
	1985	1990
All developing countries	1051	1133
South Africa	532	562
East Asia	182	169
Sub Saharan Africa	184	216
Middle East & North Africa	60	73
East Europe	5	5
Latin America & Caribbean	87	108

Source: The World Development Report 1992

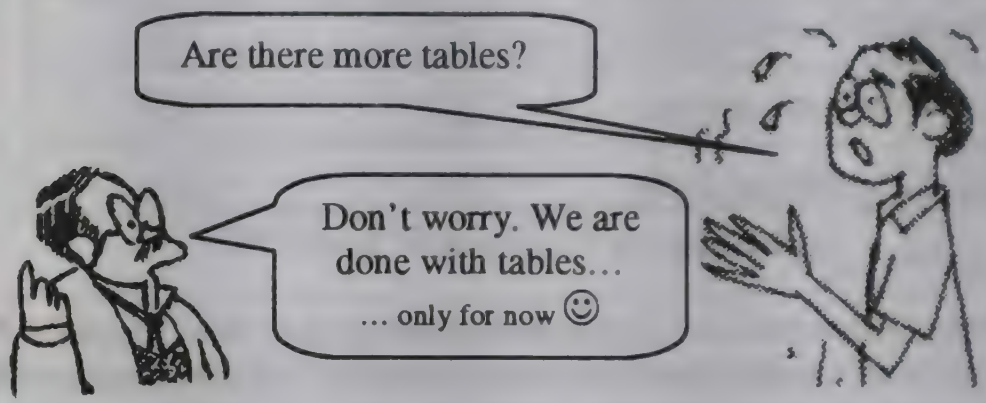
The percentage of population below the poverty line is yet another indicator to show the appalling situation after the intervention of the international agencies.

Table 3

Percentage of population below the poverty line 1985, 1990 and 1998

Region	Percentage of population below poverty line		
	1985	1990	1998
All developing countries	30.5	29.7	32.2
Latin America & Caribbean	22.4	24.9	23.8
South Africa	51.8	49	-

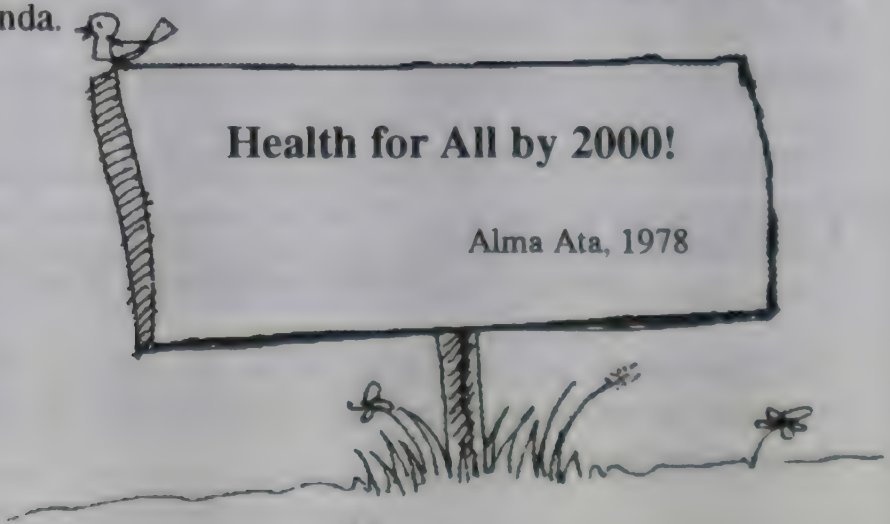
Source: Human Development Report: 1998



The World Health Organization has estimated that infant mortality rate has increased in sub-Saharan Africa, maternal mortality in Latin America and malnutrition levels in India since the implementation of SAP. In sum, the debt war declared by the WB and the IMF completely reversed the gains that the developing nations attained so meticulously in 15 years. The World Trade Organization (WTO), which is in the forefront of the drive to globalize world trade, is poised to complete the work done by the IMF/WB combine. It is estimated that when the World Trade Organization is fully operational, 2 to 6 billion people will lose their jobs and much of their land too.

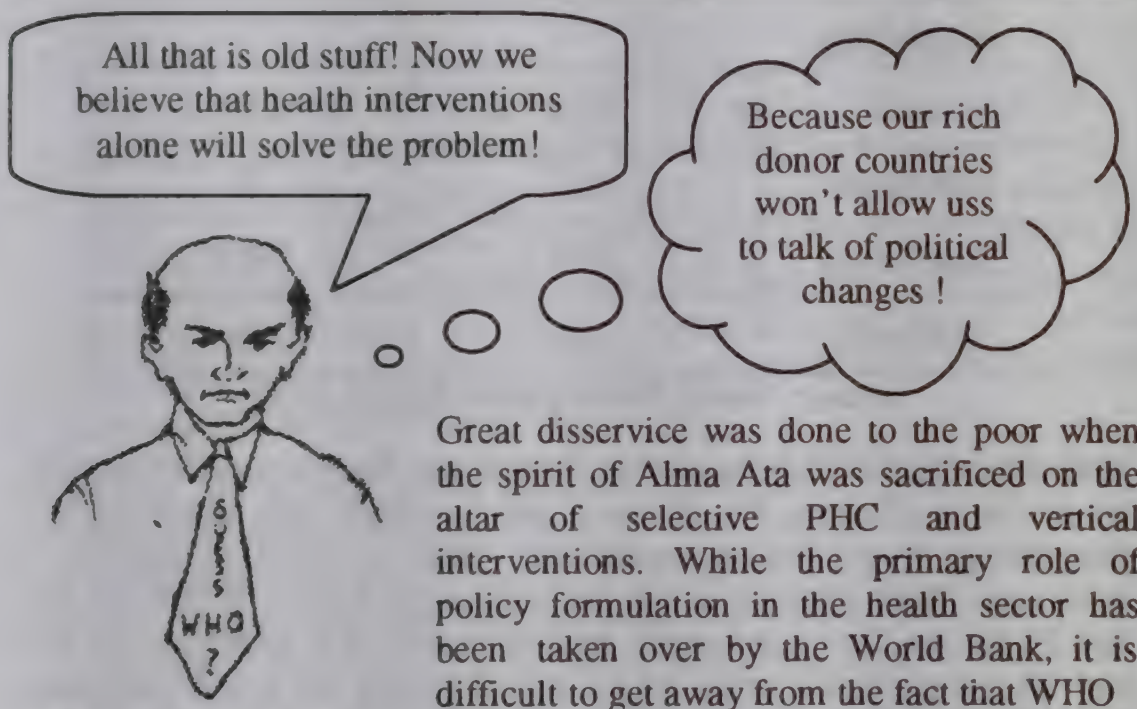
The PHC approach

The Primary Health Care approach was advocated emphatically at the Alma Ata Declaration of 1978, which has declared Health for all by 2000 as their agenda.

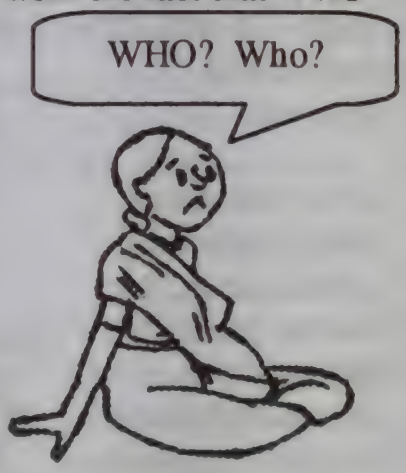


They had in their agenda stated among other things a complex set of strategies to improve people's livelihood and their quality of life by aiming to reduce the morbidity and mortality rates. The PHC approach did not deliver its goods for many reasons. Firstly, it was a vertical programme and failed to include the necessity of incorporating local health skills -- like treating diarrhea with rice water rather than spending one fourth of a daily income in buying the ORT packet. Secondly, the introduction of SAP had its own effects such as imposing user fees, freezing farm wages, freezing farm produce prices and thereby making public services inaccessible to the majority who are poor and needy. Thirdly, the World Bank's increasing role in dictating the health policies of developing countries prevented the implementation of the PHC approach.

> Health is Politics!
>
> - Halfdan Mahler
> Ex-Director General. WHO



Great disservice was done to the poor when the spirit of Alma Ata was sacrificed on the altar of selective PHC and vertical interventions. While the primary role of policy formulation in the health sector has been taken over by the World Bank, it is difficult to get away from the fact that WHO exists to soften the ugliness of globalization and is busy putting band aid on cancer. If the WHO does not start functioning at the political sphere and address fundamental issues such as resource redistribution, debt service cancellation and such, it will continue to remain largely irrelevant to the majority in the world.



The World Bank now prescribes health insurance, in place of free health services by the government. Private health insurance can in no way help the ordinary citizen in a developing nation who cannot afford to pay the premiums,

especially when they are not ill. Large members of people in the informal sector cannot afford the system. Some are only seasonally employed and are therefore more vulnerable. While the developed nations have increasingly had state support for their health services, the same nations are advocating lesser allocations in the developing countries where we have seen those below the poverty line increasing in absolute numbers:

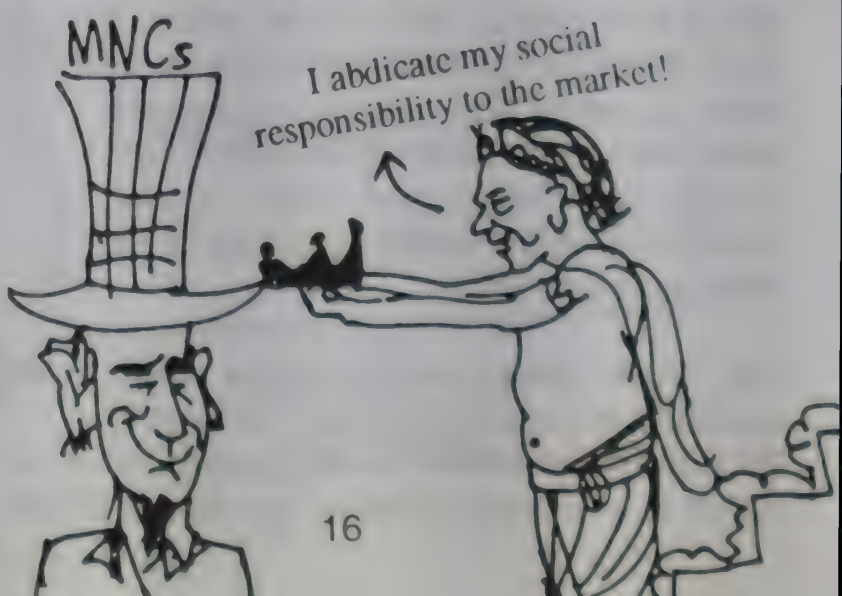
Table 4
Financing of the health sector

Country	% of Govt share	% of Pvt. Share
Developed		
Canada	74.7	25.3
Sweden	89.8	10.2
UK	85.2	14.8
Developing		
India	21.7	78.3
Philippines	50	50
Bangladesh	43.8	56.2
Indonesia	35	65

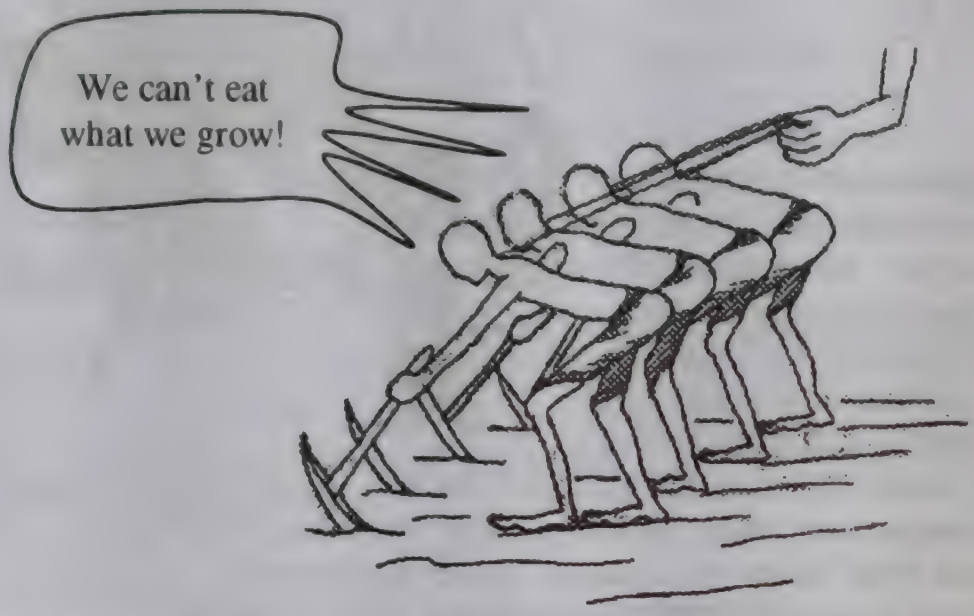
Source: World Development Report, 1993.

With state allocations continuously decreasing, the marginalized sections are the most affected. For instance the "outcaste" and tribal (SC/ST) populations in the Indian context are badly in need of the state's assistance. Their illiteracy levels are alarmingly high at 62.6% for SCs and 70.4% for STs. It is equally painful to note that 49.6% of the SCs and 64.5% of the STs drop out of school during the higher secondary stage. Around 70% of the SC/ST population earns their livelihood as agricultural laborers.

In the context of liberalization and globalization, the state is gradually abdicating its responsibilities to society. This forces the marginalized sections to compete



in unfavorable conditions, more so since globalization has displaced traditional occupations and agriculture with several mechanized activities. Orissa's worst affected district Kalahandi produces more than the national average of rice but very few of the poor there can afford to buy it.

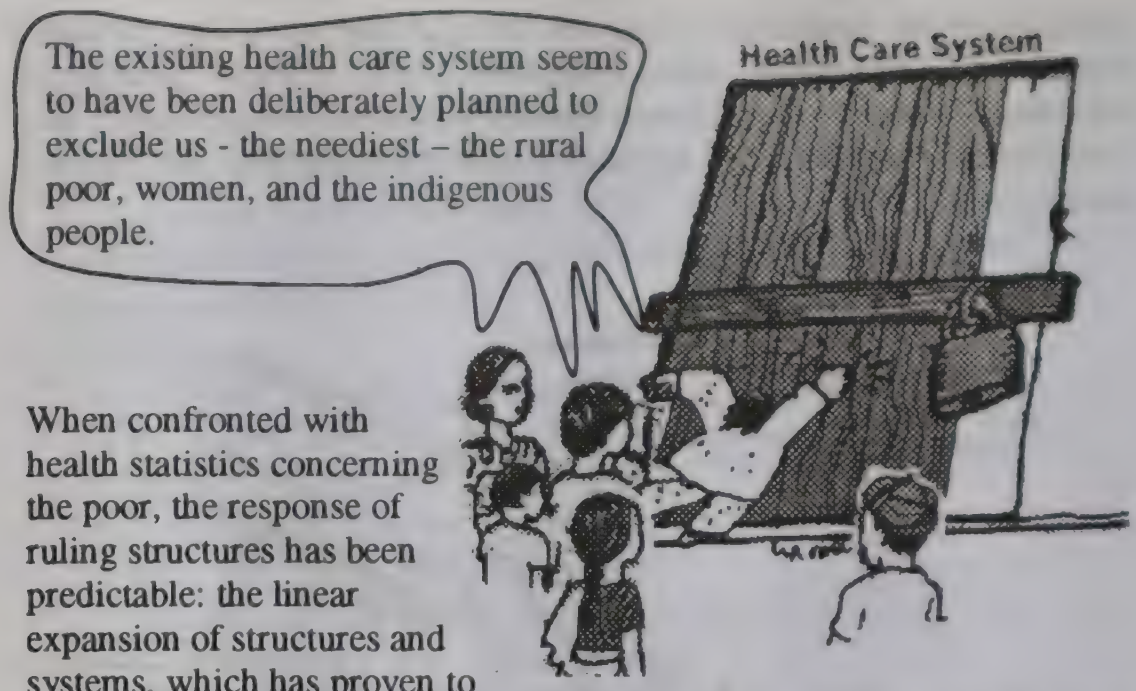


The introduction of cash crops has proved very expensive and unmanageable. Crops like cotton and tobacco have replaced traditional coarse grains like Bajra and Jowar. The poor have lost access to a relatively low priced, but rich source of nutrition provided by these coarse grains. The new cash crops are especially vulnerable to pest infestations and there are periodic cycles of crop failure - a situation which has led to a spate of suicides by farmers in Western and Southern India in the last few years.

While the income levels go down, prices tend to go up because of several reasons: imports of specific commodities such as fruit juices, chocolates, cheese and other luxury products to satisfy the wants of the rich, the export of raw materials and other cash crops to pay for these, and price fixation on the imports by international agencies like the WTO, the increasing imbalance in trade and the weakening of national currencies with devaluations and currency fluctuations and the resultant inflation. In all this, the role of Multinational Corporations (MNCs) has been central. While it may appear that the poor are peripheral to this process, it has been demonstrated that they feel the ultimate effects.

Issues in the Health Sector

In Asia, as elsewhere in the third world, budget allocations continue to be made not based on the real needs of the majority but needs as seen through the eyes of the of the ruling elite. Specifically health and education seem to receive step-motherly treatment while defense allocations on the other hand are steep.

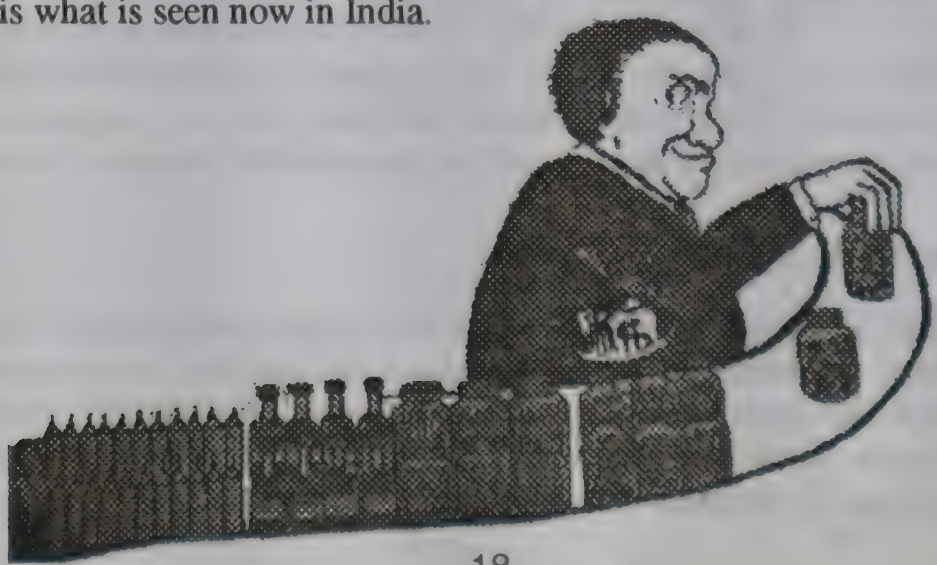


When confronted with health statistics concerning the poor, the response of ruling structures has been predictable: the linear expansion of structures and systems, which has proven to be ineffective over the past five decades. More medical schools, more infrastructure, more buildings, more vehicles, more vertical programs with their cadre of workers, more sophisticated technology, always biased in favor of urban, upper classes and upper castes.

India needs more para-medical staff instead of this system, which, with its many post graduation institutes, has produced more doctors and specialists. This makes the health organization-management set-up insensitive to the health needs of the majority of the poor. The health services, as it stands today, is badly in need of a strong village-level and people-centered organizational focus. Historically speaking, the poor were always denied effective public health services and today, with the onslaught of globalization, we are in a definite mess.

The Pharmaceutical Sector

The major impact of the WTO provisions especially the Trade Related Intellectual Property Rights is in the pharmaceutical sector. A good case in point where TRIPS is going to destroy a self-reliant pharmaceutical sector is what is seen now in India.



India has one of the most progressive patent laws passed by the parliament in 1970. The major features of the Indian Patent laws are that it is based on process patents rather than on product patents. This means that when a new drug is marketed anywhere in the world, we can manufacture the drug in India through a different process using indigenous capabilities. Also the patent period for drugs and pharmaceuticals is only 7-14 years. Microorganisms and life forms cannot be patented in India. Also when a drug company is given patent rights in India the drug will have to be manufactured in India itself. It is because of the Indian Patent that India has become one of the very few developing countries in the world (others being Brazil and China) that has attained near self-sufficiency in essential drug production.

Before 1970 it took nearly 10-15 years for drugs marketed in developed countries to appear in the Indian market. But after the Indian Patent act came into operation newer drugs that were marketed in the developed countries were produced either by the Indian public or private sector within 3-5 years or even earlier.

Table 6

Introduction of New Drugs in Indian Market

Drug	Production in Foreign Countries	Production in India
Before 1970		
Sulfadiazine	1940	1955
Penicillin-G	1941	1963
Streptomycin	1947	1963
After 1970		
Salbutamol	1973	1977
Rifampicin	1974	1978
Norfloxacicin	1987	1988
Mebendazole	1977	1978

It is because of the indigenous production capability that Indian drug prices still remain one of the lowest in the world.

Table 7

Drug Price: Comparison (In Indian Rupees)

Country	Ranitidine 150 mg x 10	Diclofenac 50 mg x 10
India	7.16	5.64
UK	320.85	125.88
USA	739.60	505.68

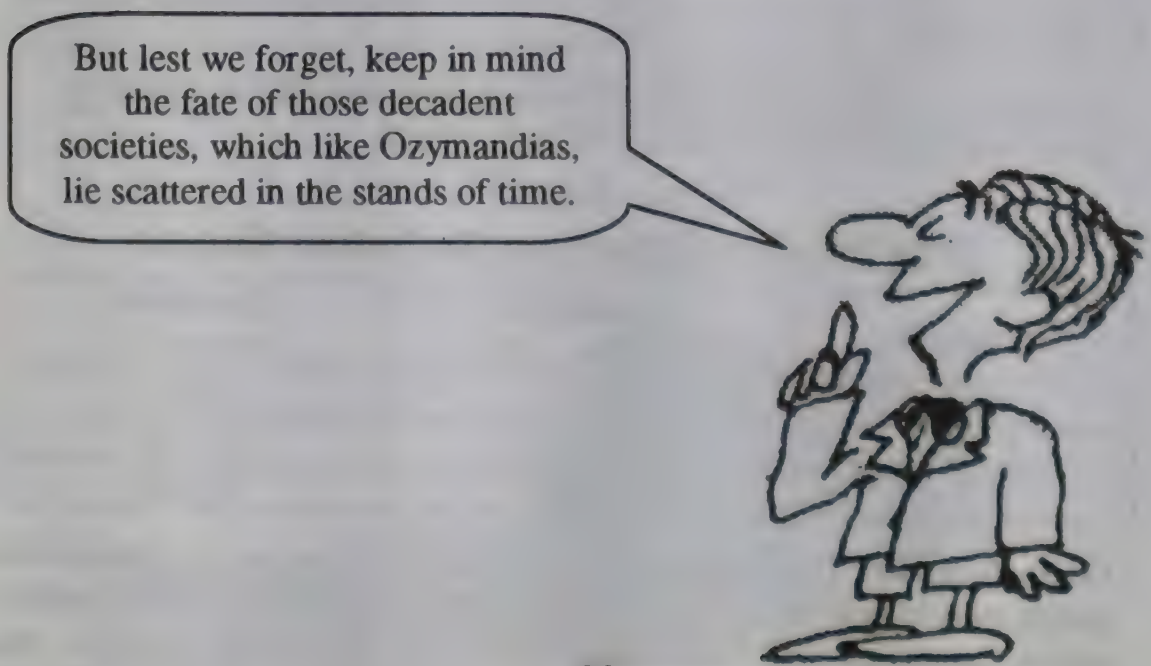
Once, as per the TRIPS agreement, the Indian patent law is changed the patent period will be 20 years and instead of process patent, product patent provision will come into existence. This will result in the dominance of the multinational drug companies in India and will

completely destroy our self-reliance in drug production. Drug prices will explosively rise and since the government health expenditure is already being cut down as per SAP, health care in effect will be denied to more and more sections of the people.

From Gamma to Gates

Historically the problem started with the arrival of Vasco da Gamma on the west coast of India on 28th May 1498. The spices and other natural resources with which India was well endowed then were the lure. Gamma was merely the first of the adventurer-merchant princes, the latest being Bill Gates. Only the nature of the goods being traded has changed but from the beginning, the key characteristics associated with globalization have been greed, profit maximization, exploitation of nature and human beings, unequal trade, control by any measure - either through the East India Company or through the WTO. In capitalism, it is the survival of the fittest, the strongest, and the most cunning. It is a jungle where the weaker ones get eaten up. Globalization is a systematically planned process of capitalism for the domination of this Unipolar world where the rules of the game are drawn up by the rich, codified by the World Bank and International Monetary Fund and implemented by WTO, all forums in which the voice of the poor goes unheard because they are indebted.

This is not entirely out of the blue. Historically, right from the time of the Greek city-states through the Roman Empire and through the later centuries, as attested by biblical incidents, slavery has formed the basis of capitalistic accumulation in the past. Globalization is but an extension of the concept of slavery and is the ugliest face of capitalism yet.



The World's Priorities

(Annual Expenditure)

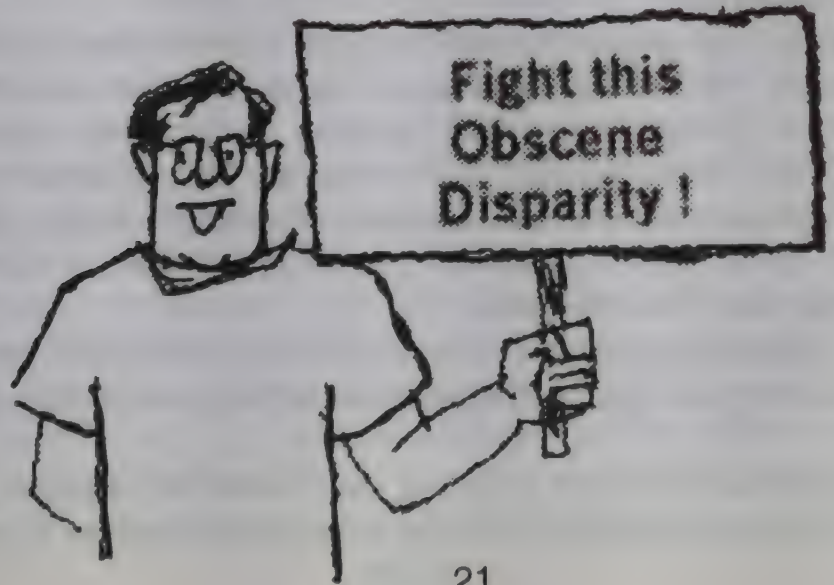
Basic Education for all	**$6 billion**
Cosmetics in the USA	$8 billion
Water and Sanitation for all	**$9 billion**
Ice cream in Europe	$11 billion
Reproductive Health for all Women	**$12 billion**
Perfumes in Europe and the USA	$12 billion
Basic Health and Nutrition	**$13 billion**
Pet Foods in Europe and the USA	$17 billion
Business Entertainment in Japan	$35 billion
Cigarettes in Europe	$50 billion
Alcoholic Drinks in Europe	$105 billion
Narcotic Drugs in the World	$400 billion
Military Spending in the World	$780 billion

Source: Human Development Report, 1998

Consumption Patterns in the World

Consumption Item	Richest 20%	Poorest 20%
Total private consumption expenditure	86%	1.3%
Meat and Fish	45%	5%
Energy	58%	4%
Telephone lines	74%	1.5%
Paper	84%	1.5%
Vehicles	87%	1%

Source: Human Development Report, 1998



What is to be done now?

There are certain steps that need to be catalyzed in order address the situation. Strategies should be developed so that the poor are able to handle the immediate effects of globalization. Long term solutions will depend up empowering peoples organisations which can effectively plan for there needs and also have a major role in national governance and policy formulation -- including policies that actively resist the forces of globalization, which are detrimental to the conditions of living of the poor and marginalized.

Strategies have to be centered around:

- Improving conditions for good governance, involvement of people in local governance irrespective of class or caste, community participation in identifying priorities, making financial allocations and management of resources, both material and human.
- This will mean devolution of power to lower, local levels and result in decentralized management of all sectors, specially the public health sector.
- A redefinition to "public health" i.e. from the old government type, giver-receiver type of relationship to placing the local community at the center of the scheme, where the poor have the capacity to make decisions that affect their lives.
- There is a definite need to develop a workable infrastructure to implement policies and strategies, which affect major health problems in providing curative and rehabilitative health services including health promotion.
- In the twenty-first country the 'Health for All' proclamation should no longer remain a mere slogan but be put to effective action.
- A periodic consultation and dialogue with peoples organisations, government and the international agencies is a must at global regional and national levels.
- There should be large alliances and networks among peoples organisations.
- Working with people to build people's movements is a definite necessity. NGOs can be catalysts in the process of creating an effective critical mass and helping them voice their rights specifically to the decision markers and the policy markers.
- This people-centered and localized approach should effectively build on the felt-needs of the people giving them a lead role in shaping their owns destinies.
- This approach is the need of the hour to improve health, and protect and develop the existing traditional knowledge and skills.

Such an approach will help to expose and counter the negative elements of globalization as experienced by the developing countries in particular.

People's knowledge systems and skills must be preserved, refined, built upon and propagated so that they do not have to rely on global forces for services.

The Role of NGOs and Peoples Movements

Globalization as a force cannot be countered by the 'disadvantaged' in a straightforward manner. But there is still a lot that they can do. Consider the fight against Cargil in Karnataka or against Monsanto in Andhra and elsewhere. People's power is immense. It just needs to be harnessed. It is in this that NGOs and peoples movements have a vital role to play.

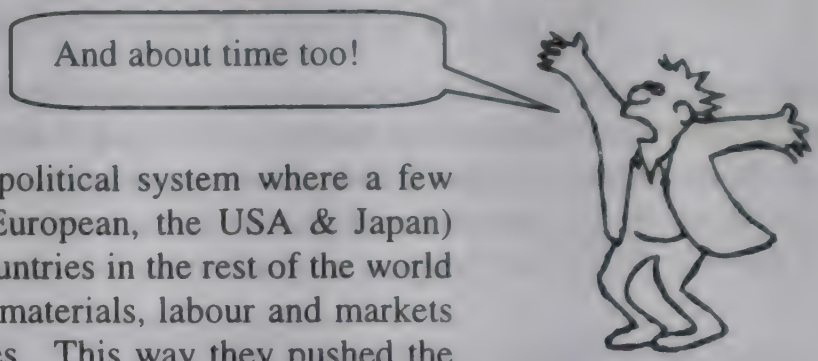
In brief, three thrust areas suggest themselves:

- **An Advocacy Role**: whereby relevant information is placed in the public eye. This information, to a large extent, already exists. It only needs to be 'interpreted' in favor of the poor and where no information exists, it may have to be generated. This is the age of information and information leads to knowledge and knowledge is power.
- **A Training Role:** which equips activists, trainers and communities with the knowledge and capacity to strategies and fight against forces of oppression.
- **A Networking Role:** which enlarges the community of believes and practitioners and brings about a critical mass that can effectively fight on the side of the barricades, in the poor for justice in health care.
- **Building Resistance:** Above all peoples organisations can join together to build a resistance, both against the philosophy of globalization and in its actual manifestations that touch the lives of common people in thousands of ways.

Global strategies of poverty alleviation have all aimed at maintaining the status quo by providing for example, minimum wages as opposed to living wage, mid-day meal for children of the poor as opposed to just wages, reservations and quotas instead of equality and justice, ORT instead of potable drinking water and so on. But history has proved time and again that a people, even the most supine of them, can be pushed only so far and no further. Existing disparities have been sharpened and have gone from mere inequality to the inhuman. The developed nations of the North can discount this only at its peril. At the turn of the millennium, unless structural problems are addressed urgently, humankind will be headed for a prolonged period of unrest and violence. If we are silent observers, we will stand indicted by posterity as having colluded with this process.

Chapter II

Understanding the Jargon !



Colonialism: The political system where a few countries (mostly European, the USA & Japan) conquered other countries in the rest of the world and used their raw materials, labour and markets to enrich themselves. This way they pushed the colonized countries into poverty.

Imperialism: The advanced stage of capitalism characterized by the emergence of large monopolies. The world is in this stage divided into spheres of influence and the export of capital is the major feature of this stage.

Food Security: A policy that ensures that all the food needed for a country is grown and stored within the nation, thus ensuring security from famines in the event of a natural or human-made disaster. Having such food security also means that as a nation our sovereignty is safe for if we needed to beg for food in a famine we would be forced to capitulate to their dictates.

Gross Domestic Product (GDP): This is one measure of a country's wealth. It is derived by adding up everybody's income. Equivalently, it is the total value of all products and services in the year. The problem with this index is that if a few persons increase their income/production considerably, even if there is a decline in the majority's income, the GDP would still go up! This figure hides inequalities.

Globalization: Refers to a set of economic and political policies that believes in taking down all barriers to the creation of a single global market as the best prescription for prosperity. Multinational corporations welcome this and so do all large, rich and powerful companies everywhere. For them the removal of national barriers means that they have a much larger market. However in most countries small producers and even small industries that cannot compete with the larger companies oppose this. In a free market they claim, the rich are free to do what they want, but the poor are pushed out. Globalization does not only create a global market by removing trade barriers. It also creates a homogenous global culture. Technology development, the creation and control of knowledge and information and the structure of social institutions are also shaped to favor the domination of the few multinationals.

Inflation: An economic trend in which the value of paper money falls. Therefore the prices of all goods rise. Inflation robs the worker of his/her wages - for it means his/her (effective) wages are lowered regularly. For property owners however it means no change in real value or that cash value of their property goes up.

International Monetary Fund (IMF): An international financial institution floated by the powerful countries of the West to help manage the international financial situation. It lends to developing nations. When nations are forced to plead for loans or are unable to repay loans it demands that these nations change policies to suit the interests of rich nations in return for the loans.

Liberalization: A political policy where state controls over production and trade are removed or are decreased considerably. The understanding stated for removing these rules is that the market is a better judge of people's needs than the government. Critics of liberalization point out that social goals of production especially to meet the needs of the majority who are poor and the goals of employment generation are bypassed by such liberalization and only the rich benefit.

Liberalism: Refers to an economic philosophy that believes in abolition of government intervention in economic matters. No government restrictions to manufacturing or trade. Such free trade was supposed to be the best way for the economy to develop. It was expected that when free trade was allowed, competition between producers would ensure both the best quality and quantity of goods and jobs for all. However by the middle of the last century this was challenged and during the nineteen thirties much of this was given up. Capitalism instead came to follow the theories of Keynes who challenged liberalism and called on governments to intervene to ensure full employment, stating that this was necessary for capitalism to survive and grow.

Multinational Corporations (MNCs): These large companies span many countries & continents. Most of them have huge assets, often more than the total budgets of many poorer countries put together. They do not come under any one country's laws. Their decision making process is totally invisible and they are not accountable to anyone but their own board whose only criteria is profit. Yet because of their tremendous resources they can influence the policies of governments with ease.

Neo-Colonialism: This refers to policies of rich countries that force developing countries to export their raw material at relatively low prices & become a market for their industrial goods and manufacture, without direct rule as in the colonial period. Through indebtedness, unequal treaties and through trade terms the rich countries maintain control over

the poor and extract as much profits from them as possible. Often the amount extracted is more than what happened during colonialism.

Neo-Liberalism: This is the revival of liberalism in the 80s and 90s. Its main content is that an unregulated market is the best way to achieve economic growth that benefits everyone. Though the rich would benefit more, some benefits would trickle down to the rest. Whereas liberalism foresaw a role for the state in social services and some activities called "public good", neo-liberalism tries to find market solutions even for these. In areas like health, education and social security the poor have to fend for themselves and if they fail it would be "because they are lazy."

Privatization: This is the policy by which, a government hands over all public sector undertakings and services provided by it to private hands.

Recession: An economic crisis caused due to insufficient demand, when goods manufactured fail to sell. This means big losses to industrialists and restricts industrial growth. This in turn means workers are laid off, resulting in high degrees of unemployment.

Structural Adjustment Programme (SAP): The IMF and World Bank impose these policies on indebted nations as a condition for deferring their loan repayments or giving them a fresh loan. These conditions, which are usually kept secret, dictate to the indebted country how the economic structure and certain aspects of government laws and regulations must be changed.

World Bank (WB): This is an international bank whose largest shareholders (and therefore effective owners) are the rich nations of the world, mainly the USA. Like any other bank it accepts deposits and lends money. Its depositors are the rich nations of the world. It lends largely to developing nations, supposedly to help development. But it will lend only when it can determine what development the money is going to be used for. Also, it lends only to support development as understood in the west. In the area of health, it even works out in detail the health programmes for which it lends. These are not grants or aid. These are all payable back with interest.

World Trade Organization (WTO): This is an international body composed of all the nations of the world who have signed international trade agreements (most of which are against the interests of developing nations) and have been admitted into it. It is meant to lay down the rules, settle disputes and police the implementation of trade agreements between nations. It is dominated by the west, but since all nations have some representation, they can also put forth their views and bargain before this body.

Chapter III

What Every Indian Should know About the Financing of Health Care in India!

Do You Know?

1. Indians spend less on health (as compared to expenditure on food, clothing and entertainment) than other nations.

True / False

2. Compared to other nations, especially the west, India has a larger % of public health expenditure (compared to pvt. expenditure).

True / False

3. Compared to other nations, Indian government expenditure on defense as compared to expenditure on health and education taken together is one of the lowest.

True / False

4. Govt. expenditure on health has steadily increased over the years.

True / False

5. Most government health expenditure goes to rural areas.

True / False

6. States with worse health status spend more on health care (as they should).

True / False

7. Family planning (FP) is a major part of govt. health expenditure.

True / False

8. Maternal & child services take up a major part of FP expenditure.

True / False

9. The per-episode out of pocket expense for in-patient health care in 1986 was Rs. 886. In 1996, the expense was double this, which is what we can expect at 10% inflation per year.

True / False

10. In 1986, the extent of utilization of the public health system for inpatient care was about 60%. This decreased to 45% in 1996.

True / False

11. Mostly, expenditure by poor households on curative medical care goes to essential drugs and basic health care.

True / False

12. Western aid, including from the World Bank, accounts for only a small part of government expenditure on health.

True / False

13. Since our country is cash strapped and the money is going to a vital area, we should be thankful for this aid.

True / False

Answers on the next page.
Score yourself ten points for every correct answer

Answers

1. **False**: Indians spend about 6 percent of their GDP on health care. (This is inclusive of both private and public expenditure). This is comparable to most developed nations (only the US is higher) and more than almost all developing countries. See the graph below. figure 1

However in absolute terms this is low. For example an Indian spends on an average Rs 250 per person per year, whereas in England it is Rs 2500 per person per year and in all Asian countries taken together it is Rs 1000 per person per year. figure 1

Figure 1 Income and health spending in seventy countries, 1990

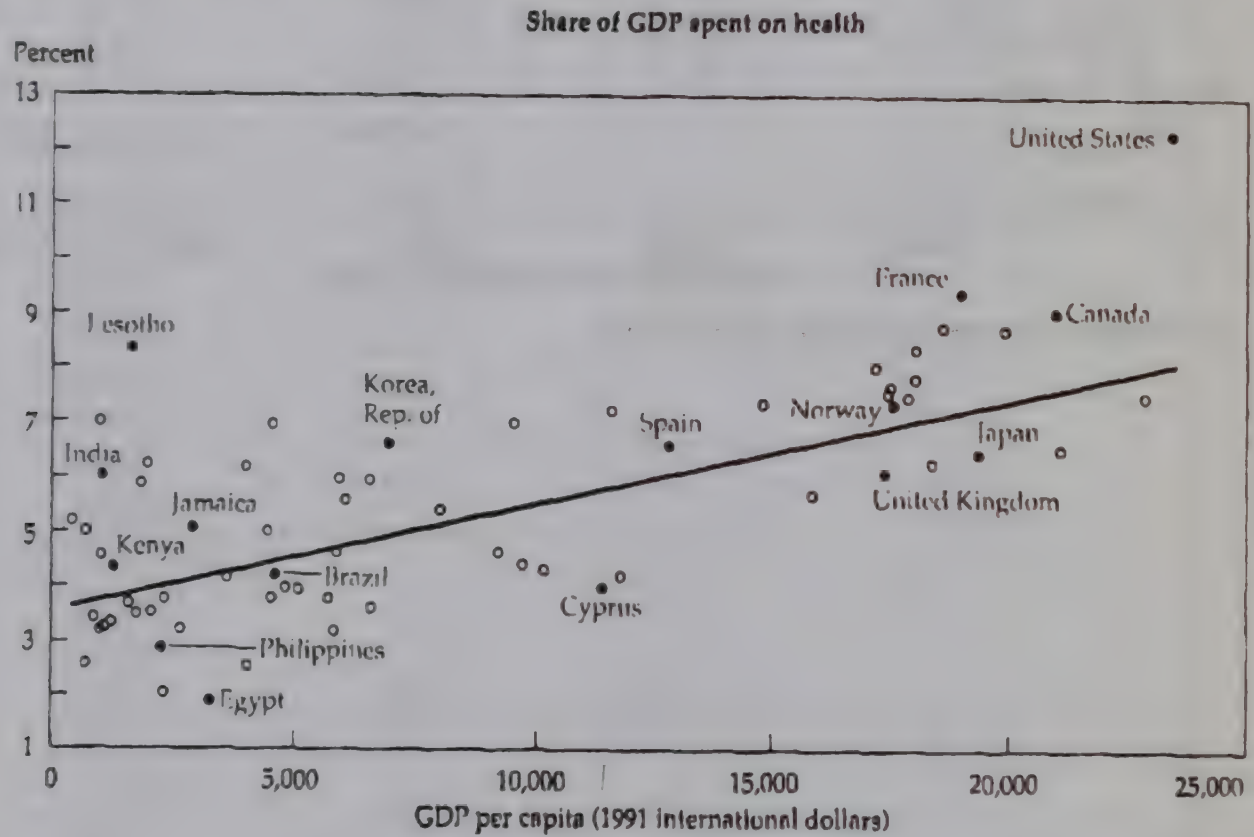
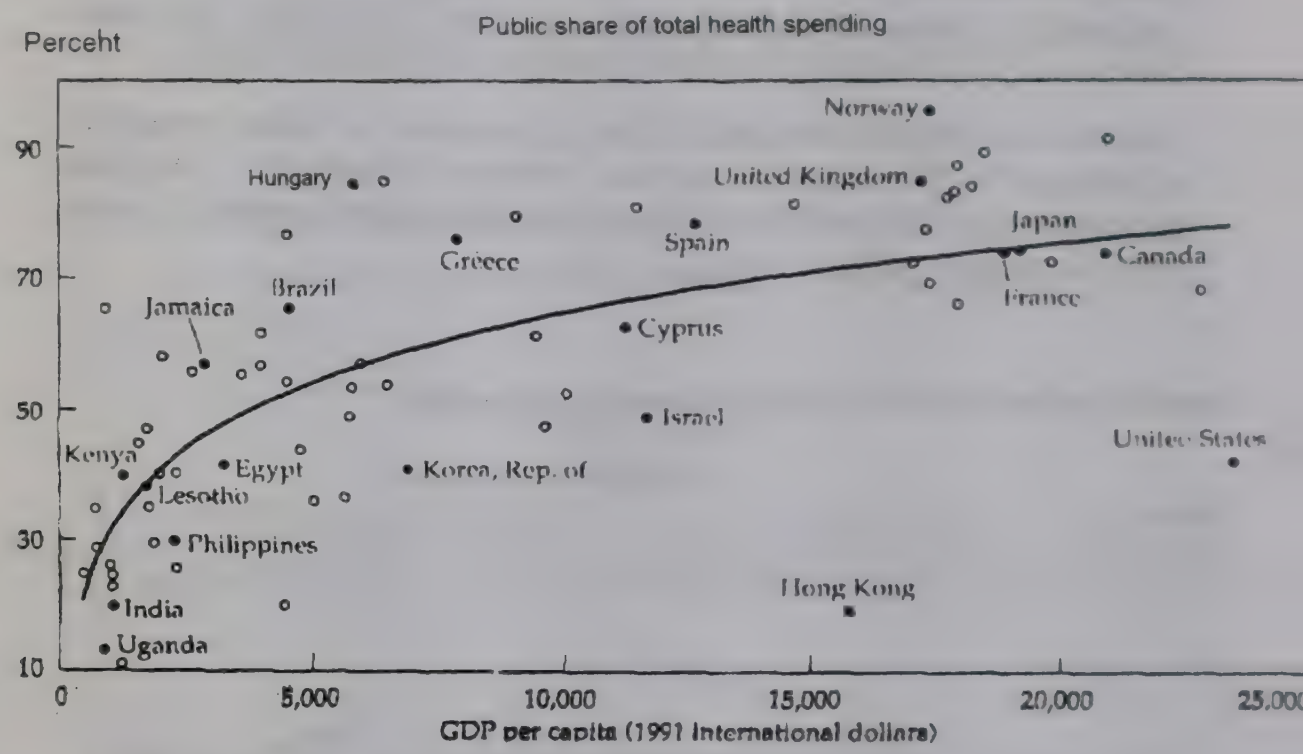


figure 1

2. **False:** The public sector share of total health expenditure is about 22%. This is about the lowest in the world. The figure for all the developed capitalist nations together is about 75%. The lowest figure for any developed nation is the US, but even there it is 44%. This is twice the Indian figure. see figure 2



Source: Murray, Govindaraj, and Chellaraj, background paper.

: figure 2

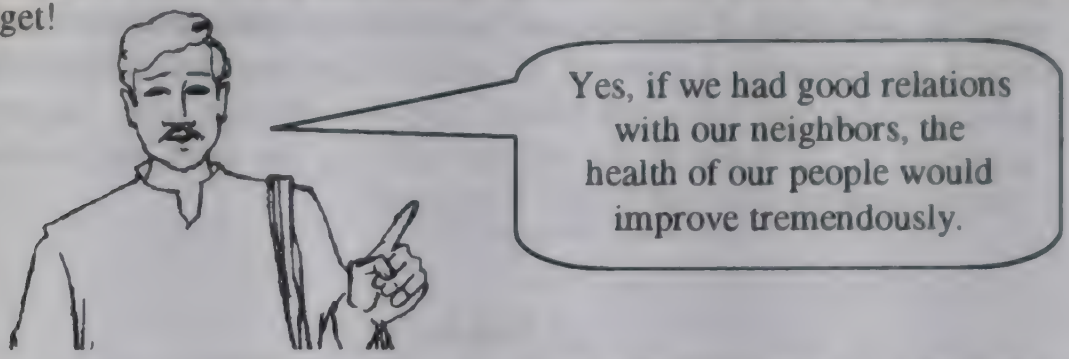
It is important to note this information because when governments and policymakers talk of privatizing in the Indian context one forgets this is the most privatized health system in the world. One other feature we need to remember is that in many western countries the state provides health care through a network of centers. But in many others it is the private sector that provided health care, but through state support the expenses of the poor or the old are paid by the state and others are covered through different forms of insurance.

TABLE - 1
Global health expenditure, 1990

Demographic region (DM=Demographic)	% of world popn.	Total health expense (billions of $)	Health expense as % of world total	Pub.health expense as % of regional total	% of GNP spent on health	Per capita Health expenditure ($)	Ratio of per capita spending (SSA=1)
Established market economies	15	1483	87	60	9.2	1860	78.9
Formerly socialist economies of Europe	7	49	3	71	3.6	142	6.0
Latin America	8	47	3	60	4.0	105	4.5
Middle East	10	39	2	58	4.1	77	3.3
Other Asia & Islands	13	42	2	39	4.5	61	2.6
India	16	18	1	22	6.0	21	0.9
China	22	13	1	59	3.5	11	0.5
Sub Saharan Africa	10	12	1	55	4.5	24	1.0
DM-ly Devp-ing countries	78	170	10	50	4.7	41	1.7
World	100	1702	100	60	8.0	329	13.7

Source: World Development Report, 1993 page 52

3. **False**: India has one of the highest ratios of defense to health and education, for a country not having a war. On defense we spend 15% of the budget while health and education account for about 3 to 5% of the budget!



4. **True**: In cash terms it has increased. However if we adjust for inflation the increase is not so remarkable. If we look at the expenditure as a percentage of the total expenditure on health there is actually a decrease in health expenditure though together with family planning it remains at about 3 %. However there was some increase in expenditure on drinking water in the eighties. This is shown in the table given below.

Table 2
Health Expenditure by Five Year Plan Periods

Plan period	Total plan investment outlay	Health	Family Welfare	Sub-total (col. 3+4)	Water supply and sanitation	Total (col 5+6)
I 51-56	19600 (100)	652 (3.3)	1 (0.0)	653 (3.3)	110 (0.6)	763 (3.9)
II 56-61	46720 (100)	1408 (3.0)	50 (0.1)	1458 (3.1)	740 (1.6)	2198 (4.7)
III 61-66	85765 (100)	2259 (2.6)	249 (0.3)	2508 (2.9)	1057 (1.2)	3565 (4.1)
IV 69-74	157788 (100)	3355 (2.1)	2708 (2.1)	6135 (3.9)	4589 (2.9)	10724 (6.8)
V 74-79	394262 (100)	7608 (1.9)	4918 (1.3)	12526 (3.2)	10916 (2.8)	23442 (6.0)
VI 80-85	109291 7(100)	20252 (1.8)	13870 (1.3)	34122 (3.1)	39776 (3.6)	73898 (6.7)
VII 85-90	220216 3(100)	36941 (1.7)	29581 (1.3)	66522 (3.0)	71227 (3.2)	137749 (6.2)
VIII 92-97	434100 (100)	75759 (1.7)	65000 (1.5)	140759 (3.2)	167110 (3.8)	307869 (7.0)
Note: Figures in brackets show percentages.						
Source: Social impact of economic reforms in India; EPW vol.35.No.10 March 4-10,pg 841,based on GOI reports						

During the reforms period of the nineties the percentage spent on health remains constant, but due to the drop in all developmental expenditures there is a sharp drop in the actual amount spent as adjusted for inflation. This is shown below:

Table 3
Real expenditure/allocation in the health sector in annual plans in the nineties
(At constant1990-91 prices in Crores of Rupees)

	Total developmental expenditure			Health expenditure		
	Center + States	Center	States	Center + States	Center	States
90-91	40062	23511	16551	659 (1.65)	189 (0.8)	471 (2.84)
91-92	39075	22839	16236	629 (1.61)	183 (0.8)	447 (2.75)
92-93	39946	23958	15988	665 (1.67)	210 (0.88)	455 (2.85)
93-94	44573	27942	16631	658 (1.48)	203 (0.73)	454 (2.73)
94-95	48482	31186	17296	780 (1.61)	273 (0.88)	507 (2.93)
95-96	54662	33518	21144	924 (1.69)	285 (0.85)	639 (3.02)

5. **False:** The government health expenditure in rural areas is 46.5% while in urban areas it is 53.5%! This 53.5% serves 23% of the population. (Source: *State of the Nation's Health* – Report of the Independent Commission, published by VHAI). Other estimates would put the rural spending as even less. Except for the primary health centers and the minimum expenditure on these, there is little that is expended in rural areas. All the medical colleges and all the hospitals and research centers are urban based. Of course, many of the urban hospitals do cater to rural areas since there are no rural alternatives.

6. **False**: On the contrary, the states with poorer health status are spending less on health per capita and as a percentage of their budget. These are also the economically weaker states and they find it much more difficult to raise the resources needed for investment in health. Thus the highest under five mortality are in the six states of MP, Orissa, UP, Rajasthan, Assam, Bihar - in that order. The poorest performance in DPT immunization for example is Bihar, Assam, MP and then UP,

Assam, Orissa. The six worst states in terms of births attended by untrained personnel are Assam, Bihar, MP, Orissa, Rajasthan & UP. The highest poverty levels were also in Bihar, Assam, Rajasthan & MP.

7. **True:** Family planning programme expenditure accounts for almost half of all health expenditure. (See table given for answer 4)

8. **False**: The major expenses are in the provision of family planning services, including payments to beneficiaries. Maternal and child care services account for only about 13.1% of this entire expenditure. Family planning expenditure accounted for 73.3 % of the expenditure. (Source: 1985 figures based on same source as question 5.)

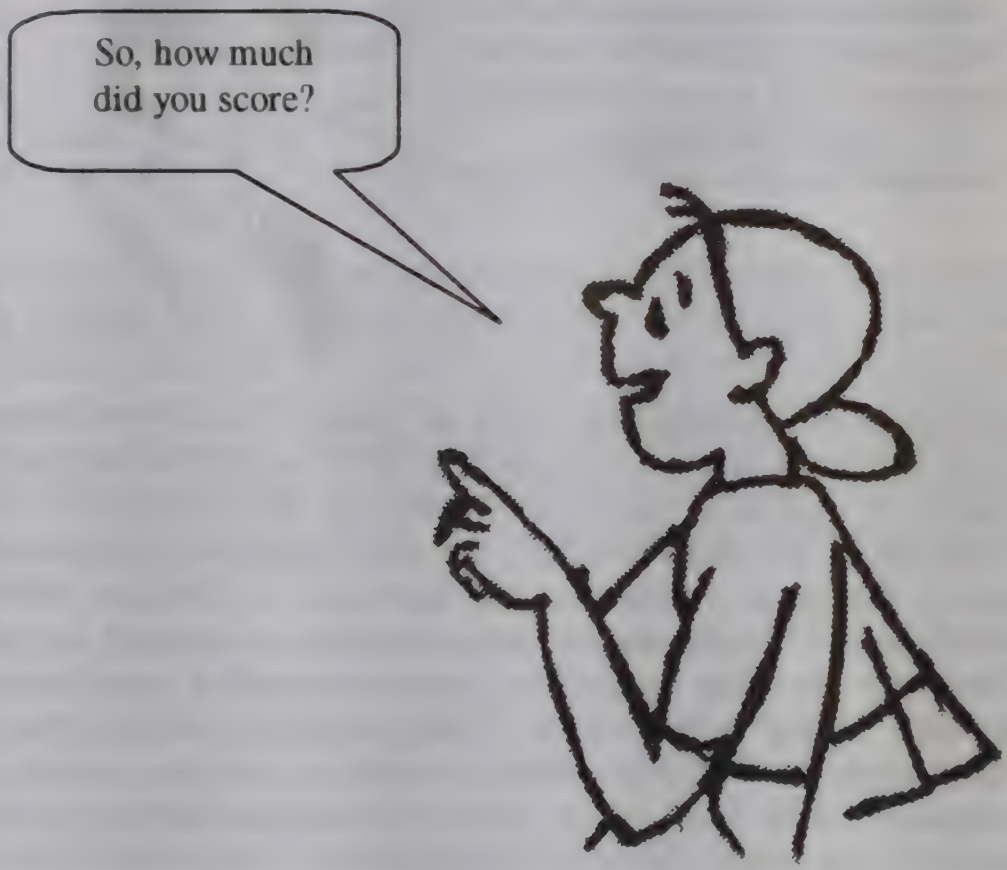
9. **False:** In reality, the out of pocket expense for in-patient care went up almost four times. At constant 1986 prices, the out of pocket in-patient care expense in 1995-96 went up to Rs. 1404 (from Rs. 886 in 1986-87). Since for low income groups, income has not kept up with inflation, the effective increase in health care cost is even more. Most conservative estimate put the health costs at more than 20% of the total family expenditure. This is one of the immediate and most evident impact of globalization.

10. **True:** The dependence on private health system has gone up from 40% to 55% for in-patient care and from 75% to 80% for out-patient care.

11. **False:** On an average 71% of the family's health expenditures go to drugs and fees and diagnostics. Transport accounts for 8% of the costs and hospitalization and surgery about 13%. Expenditure on pujas and such like account for less than 1% of the expenses. The major part of the family's expenses on drugs and diagnostics goes to inessential or hazardous medicines. This amount has been estimated from 60% (the most conservative estimate) to over 90%. Also include expenses due to choosing drugs instead of non-drug remedies or homemade preparations for symptomatic relief instead of drugs (like cough remedies). This is as true if not truer for poor families. For example, the most common expense is on diarrhea treatment, which may cost from Rs 20 to Rs 50 for treatment without hospitalization for a mild to moderate treatment. Yet rational therapy could achieve the same therapy with no expense except the consultation of the local health worker. (Source same as for answer 5 and also Rational Drug Usage by Anant Phadke.)

12. **True:** According to a world bank estimate, the entire foreign aid and loan contribution to health in India is less than 9% of the total health budget.

13. **False:** For one, what we receive as loan and aid is only a small part of what flows out of our country to these countries as profits and products. Secondly even of the amount received as aid and loans, a fair percentage flows back to these countries as consultancy charges and as commodities and equipment bought from these countries. Thirdly, the aid or loans given are not disinterested. They extract a price in terms of forcing us to change our policies and surrender a part of our sovereignty. Finally, it is not clear why they were needed in the first place. Such resources could have been raised in the nation. And we are burdened with loan repayments and this in turn forces us to bend further. Had we chosen different strategies of development that were based on empowering local communities we would have been more effective for less expense. It is only because we are reluctant to empower local communities, despite our rhetoric to the contrary, that we subjugate ourselves to these loans and their conditionalities.



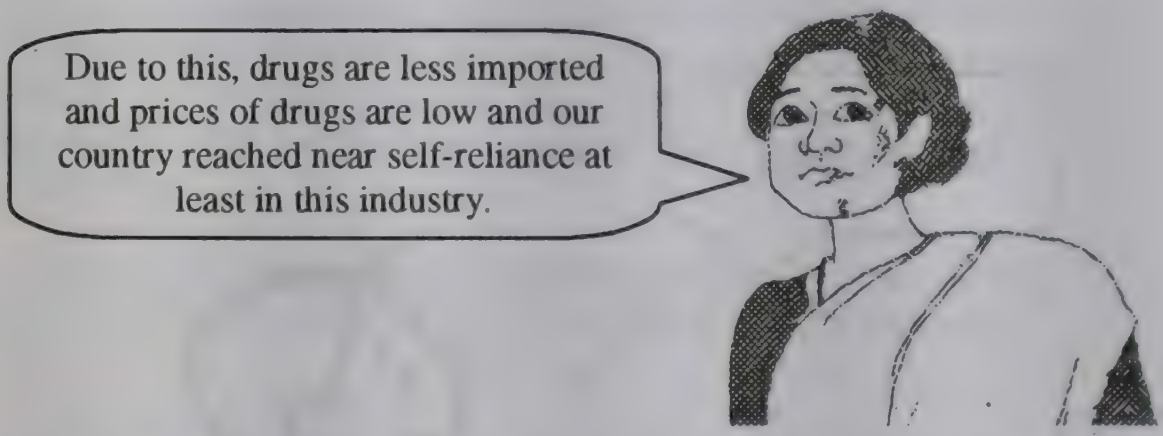
Chapter IV

The Pharmaceutical Industry

And how Globalization will take away its self reliance!

Development of Pharmaceutical Industry

Drugs and pharmaceutical industry in India has reached an annual sales of Rs.2000 Crore now. Most of the drugs are now manufactured by majority of the companies in the national sector in the country. The country has large number of technical persons and skilled workers required for production and research spread in the largest infrastructure available in the developing countries besides China.



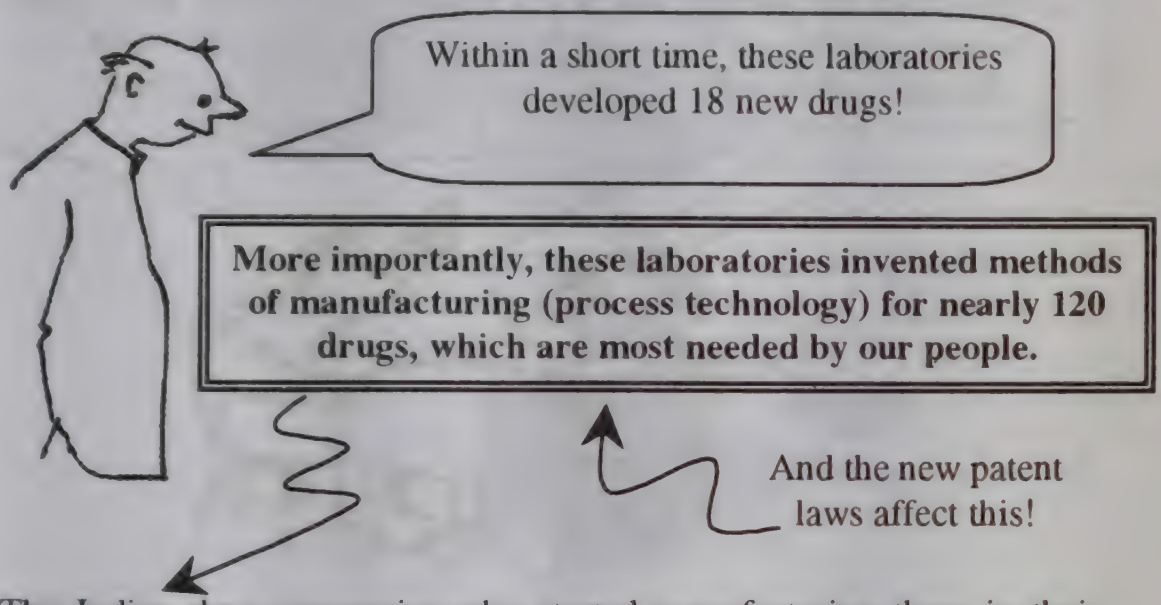
Such important development could be possible due to the industrial policy of the government declared in 1958 aiming to achieve self-reliance in industry. Same year, with the help of World Health Organization and the UNICEF, the first antibiotics manufacturing factory, Hindustan Antibiotics was developed in Primpri under the Public Sector. The developed nations in the west refused to provide technology for drug production, which compelled the country to approach former Soviet Union. With their help Indian Drugs and Pharmaceuticals Ltd. was started, which is still the largest drug company in India. Prior to this, prices of drugs in India were one of the highest in the world. After the development of the public sector drug companies, the prices of drugs started coming down. The foreign (multi national) companies were also compelled to bring down prices of their drugs and started to develop their manufacturing units in our country.

Prior to this, the multinational drug companies had monopoly and controlled the drugs market. They used to decide what drugs are to be marketed when and at what price. It was found that the multinational

companies marketed no new drugs in India until at least ten years after their introduction in the world market.

Drug Research

Before independence only one drug was invented in the country. Both IDPL and HAL had research facilities to develop drugs. Later the government established the Central Drug Research Laboratory (CDRL) at Lucknow, National Chemical Laboratories at Pune and Indian Institute of Chemical Technology (IICT) at Hyderabad.



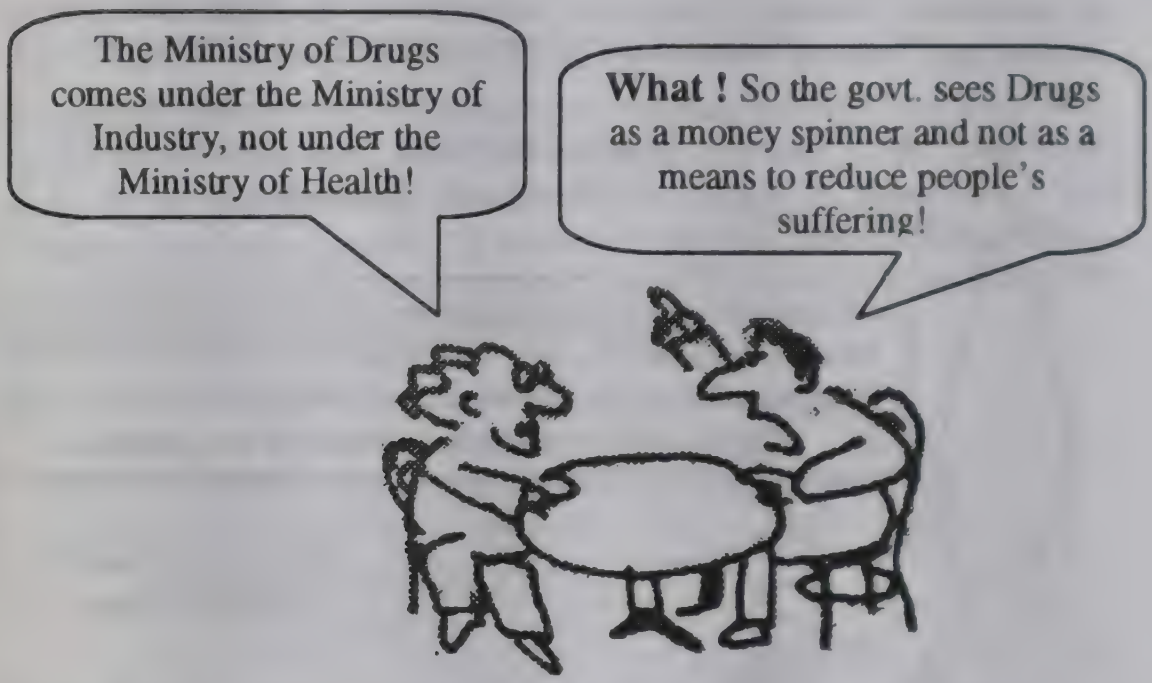
The Indian drug companies who started manufacturing them in their own factories took up these technologies. As a result, Indian drug companies were able to produce drugs very soon after their first introduction in the world market. The situation in the drug industry has undergone a dramatic change. Indian drug companies competed very well with the multinational drug companies. Now about 30 Indian drug companies have come in the list of top 50 drug companies in the country.

Not only this, Indian drug companies also competed with the MNCs in export. The Indian companies export several drugs like Ibuprofen, Trimethoprim, Dextropropoxyphene etc. to the west! Many Indian drug companies have established manufacturing units in other counties including in USA and Europe.

Drug Policy

It was declared in World Health Assembly of WHO in Nairobi in the year 1985 that no country can meet the health needs of its people without an appropriate drug policy. Even earlier, the Indian government constituted a Committee on Drugs and Pharmaceuticals known as Hathi Committee. Its report and recommendations were published in 1975.

Some of the recommendations of this committee part of the Declaration of WHO. The Committee had prepared a list of 119 drugs, which were most needed and used in the country and directed that production of these drugs should be ensured. This committee also recommended that all foreign companies should be nationalized after some time and before that foreign share holding of these companies should be gradually reduced.

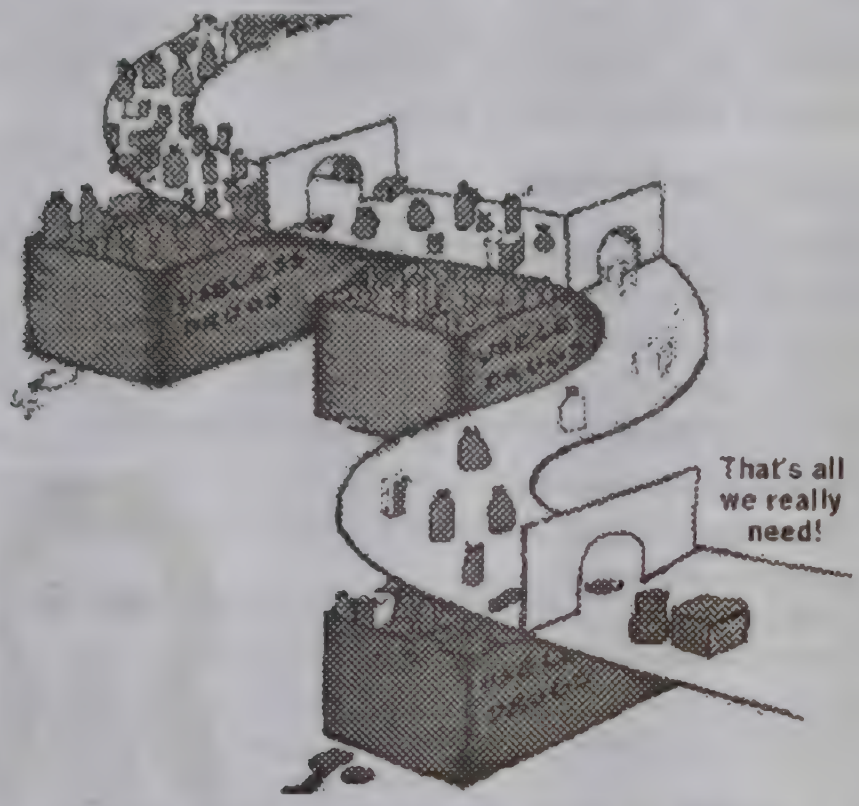


The government first declared drug policy in 1986. The policy did not follow much of the recommendations of Hathi Committee but tried to help development of national drug companies. They also provided certain safeguards for public sector drug companies. The First Drug Prices Control Order (DPCO) was declared in 1970 when **ALL** drugs were kept under price control. The next order was issued in 1987 when **nearly 387** drugs were kept under control. Now **only 63** drugs are under DPCO!

Essential drugs.

Really how many of the large number of drugs available in our country are Rational? Even the government is not aware of the number of drugs marketed in different brand names. According to government estimates made a decade ago, nearly 60,000 brands are marketed here. Many irrational and hazardous drugs proliferated the market. Most of these drugs should have been banned. It was urged that the government should prepared a list of essential drugs which are needed by most of the people to treat nearly all their diseases. The government should ensured production and availability of these drugs at affordable cost. Since drugs are not purchased directly by the patients on their choice, it

is more important that government should see that people are not dumped with irrational and hazardous drugs at high price. The government cannot depend on the industry alone to produce essential drugs but should make it an essential part of medical practice.



Though it was demanded from the government to prepare a list of essential drugs for our country, it took a decade for the government to come out with this list only in 1996. Even though the list was prepared, there is no attempt from the government to use it for rational use of drugs. In fact, no one knows where from such list would be available! Based on such a list at least the hospitals should prepare their formulary and the doctors can be asked to limit their use around the list. Similarly, the industry can also be asked to produce essential drugs without wasting limited resources on useless drugs for the sake of high profits.

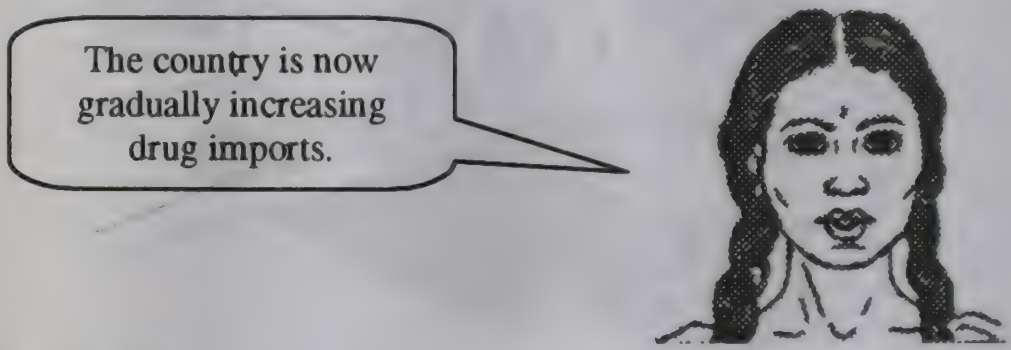
Multi-National Drug Industry

The multinational drug companies came in India with a meager investment but developed 100's of crores of assets without investing further. They did not provide much high technology, but rather drained away large sums of foreign currency by way of Profit, Royalty, Technical know-how, etc. The MNCs had first tried to disrupt the public sector and now are using them to earn profit. The strong international MNC lobby has influenced WTO to include patents (particularly Drug patents) in the GATT issues. They have also influenced our government to give up policies favoring people. It is the MNC lobby which has

threatened the US trade sanctions against Indian drug companies. The lobby has also threatened to file complaints against India at the WTO for violating patent agreements. Nearly all multinational drug companies have now closed their manufacturing units and are using small scale units to produce their drugs. This has meant laying off 15,000 workers, chemists and scientists just in Maharastra alone. The multinational drug companies confident of dominating the Indian pharmaceutical market within 3 years!

Reversal of the Process

The multinationals and government policy has systematically debunked the glory that India had earned in achieving self-reliance in the drug industry. The government first marginalized the role of the public sector drug industry and then crippled it. Now public sector drug companies are either given over to multinationals or are being closed.



Many bulk drug-manufacturing units, large and small, have been closed due to free import and dumping. On one side, the customs duty has been reduced and on the other, excise duty has been increased. This will make imported drugs cheaper but indigenous more costly. Remember that the excise duty for luxury items has been reduced!

Control of prices is now at a symbolic minimum and there are plans to totally withdraw it. The government has yielded to the pressure of the industry stating that there will be self-regulated prices due to market competition. Already prices of many essential drugs including anti TB drugs have nearly doubled within a year. On top of it, prices of all new drugs and vaccines are exorbitantly high, since they are all imported.

Of nearly 10,000 drug producers, only 500 belong to organized sector rest are belong to the small–scale sector. They had survived by producing generic drugs and supplying drugs to various government institutions. With excise duty on generic drugs and the imposition of the condition that allows only drug companies with an annual turnover of at least Rs. 12 crores, many small companies are being forced to

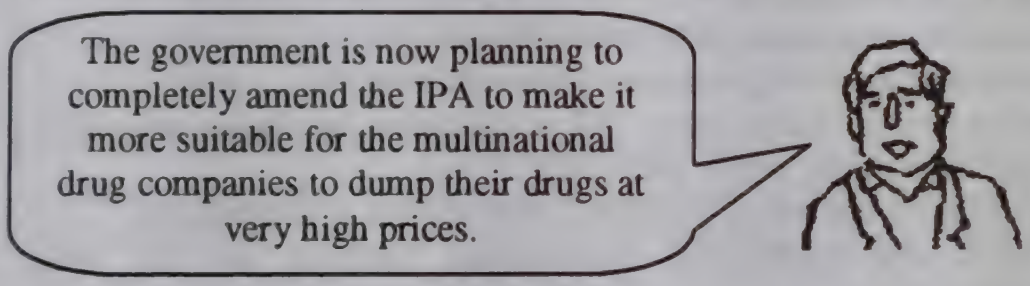
close down. This government policy will allow multinational drug companies to monopolize the Indian market again.

The government has now allowed multinational drug companies to function with 75% to 100 % foreign equity. With the change in Foreign Exchange Regulation Act, the government has now allowed MNCs to drain out not only profit but along with it foreign currency also!

Globalization and Patent

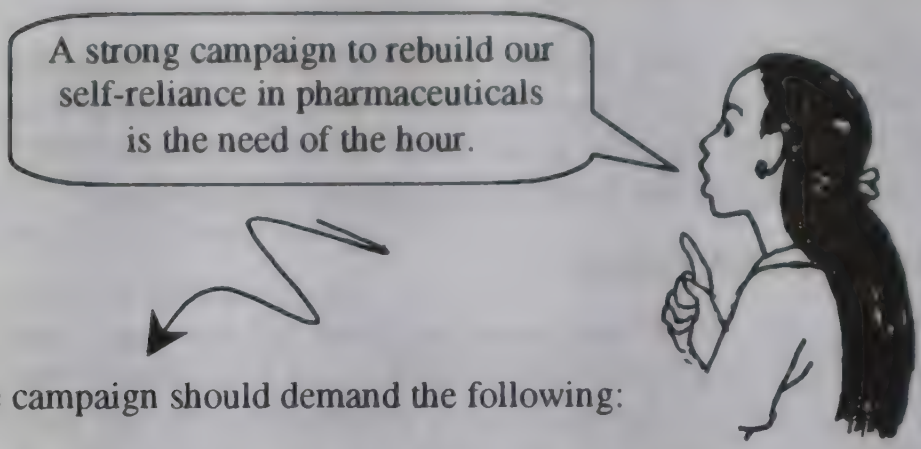
Indian Patents Act, 1970 was considered one of the most suitable regulations for encouraging development of national industries. This act has been important for the spectacular development of the national sector in drugs and pharmaceuticals. This has not allowed MNCs to compel India to import drugs that can be produced here. It has also allowed research on the development of 100's of process technology. It provided scope for introduction of new drugs almost simultaneously with their first introduction in the world market.

India signed the WTO agreement – this allowed US and European drug companies to file complaints against India for violation of the agreement. With this as an excuse, the government changed the Indian Patents Act in 1988. The change was basically to benefit the MNCs.



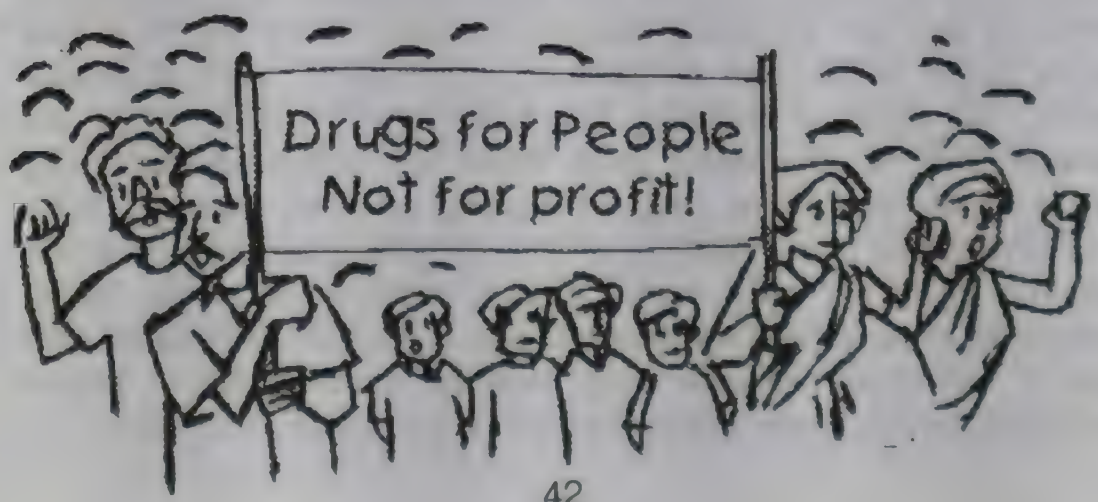
A new amendment bill has been proposed which a sub-committee is now viewing. Purpose of present amendment is to change all important section of IPA totally. This will now allow any Indian drug company to introduce any new molecule, which is patented. They will be a long patent period of 20 years for product patent and 20 years of process patent. The scope of importing any drug (parallel import) which are cheaper shall be disallowed. Even WHO has expressed that strong patent system may create crisis for treating epidemic diseases. India government had made changes in IPA to such extend that it is not required by WTO rules even. Against such action some Indian companies when to court and procured stay order. All such changes will destroy self-reliant national drug industry, creating heavy import dependencies and people will be forced to buy drugs at dollar value

What is to be done?



The campaign should demand the following:

1. Develop a comprehensive drug policy aiming to rationalize drug use.
2. Ensure production of essential drugs.
3. Develop the methodology of implementation of essential drugs list.
4. Reduce the price of all essential drugs and keep it under control.
5. Ensure that all essential drugs are available free of cost at all government run health care institutions.
6. Demand international bodies to suitably change the IPR regime for production of essential drugs. Particularly to revise the clauses on compulsory licensing.
7. Make NO changes in 1970 Indian Patents Act !
8. Encourage R&D in government research institutes.
9. Revive Public sector units. All government purchases should be made from public sector units only.
10. Screen all drugs and re-evaluate it for renewal of registration.
11. Screen and control all promotional methods by the drug manufacturers.
12. Develop and enforce a Patient's Charter!



Chapter - 5

Globalisation and Food Security

Introduction:

Food security of a nation means the ability of a nation to produce and distribute all the food grains it needs in a self -reliant manner. This would imply that one is not dependent on food imports for feeding ones population. All national economic planning since independence and upto the last 15 years or so have always had food security as one of the most important and central objectives of economic planning. For a family or community food security would mean a reasonable assurance of being able to obtain the food it needs for survival throughout the year.

Why is Food Security so Important ?

- Food security is the cornerstone of our economic and political independence. If we are dependent on food imports for survival then we are open to adverse political pressures, even political blackmail by food exporting nations. Food security is therefore a question of our sovereignty.

- Another basic reason why food security is crucial to us is the fact that chronic hunger and malnutrition is widespread in India. The total poor in India is estimated to be 320 million in 1993-94, up from 304 million in 1997-98.And this is when poverty is defined by the inability to afford even the basic minimum calories needed for an average person. For almost 90percent of the population the share of income that goes to purchase of food is above 50 percent. For the poorest 50 percent of the population it is over 70percent.In such a situation any food scarcity, however transitory and consequent rise of prices will have grave consequences for food consumption. Similarly any fall in wages, either in money terms or consequent on inflation will have an immediate adverse impact on food consumption.

- Since food consumption is the single most important determinant of good health, the impact on health would be terrible. The great Bengal famine of 1943 is a grim reminder of what "terrible" means. Over 40 lakh dead, and numerous villages ruined and all social life thrown into chaos. And that famine was a direct consequence of war related policies of the colonial state. It must be remembered that all through

the first half of the century famines and epidemics racked India. It was only after independence when the state intervened to control exports, and to import food in times of scarcity and manage distribution that such famines have lessened. Over 30 years of planning the Indian state built up carefully its ability to produce all the food that the nation needs. (But even now due to poverty and faulty distribution policies starvation deaths are still a continuing phenomenon).

- Such scarcity affects women more. The allocation of food within the family is such that women and that too the girl child bears a disproportionate reduction whenever there is a reduction of food availability. In 35 percent of rural households that are women headed the impact is even greater. The impact on women health of adverse developments in food security is immediate and grave.

How has WTO undermined Food Security?

The major economic changes consequent to the structural adjustment programme and India's accession to the World Trade Organisation have major implications for our food security. International trade in agriculture and food products is now regulated through the Agreement on Agriculture(AOA) agreed during the Uruguay Rounds. When finally agreed the AOA was based on a bilateral negotiation between the US and the European Union. Many developing countries were opposed to the AOA, but since it was presented as part of the comprehensive package, to be accepted on an 'all or nothing basis,' they were forced to concede.

The AOA is divided into market access, which deals with tariff barriers and import quotas and domestic support programmes such as price support to farmers and export subsidies.

Let us look at each of these areas:

1. Market access: As per the WTO obligations India has to reduce all import barriers on over 2700 items, of which over 800 are agricultural items. This includes milk and milk products wheat, rice, pulses, livestock, agricultural chemicals, tea rubber and so many other commodities. Succumbing to this pressure, over 700 items went off all quantitative restrictons this year. Now this has already created a crisis in tea and rubber industry where lakhs of workers are unemployed as result of their plantations being unable to face the competition from cheaper imports.

This danger of loss of livelihoods will now spread to milk and milk products where millions of women earn their livelihood and even to growing cereals like wheat and rice.

2. Support to farmers and export subsidies: The AOA lists a number of subsidies to be reduced over time.

These include direct subsidies, sales from stocks by government at lower price than the domestic market, subsidized exports —to name a few. In India this means that there is pressure to lower government procurement and support price policies. Indian farm exporters do not get direct export subsidy. The subsidy on fertilizers is sought to be lowered greatly . But the countries to which the Indian farmers are allowed to export or with whom they compete get extensive subsides for agriculture. Almost all-western nations subsidise exports. The US subsidy on wheat export was around 30$ a tonne. To China it exported at 60$ subsidy for every tonne. In the industrialized countries put together more than 182 billion dollars are spent on export subsides and the treaties have been signed in such a way that they are permitted to keep these subsides at least till 2003 while we have to remove ours. Do you know that there are farmers in England who are paid about one lakh pounds(about 70 lakh rupees) every year for not growing anything!! Just to keep their land fallow. How on earth can our farmer compete with them in the world market!

The WTO's justifications:

1. The proponents of the WTO agreements argue that it is cheaper for countries like India to buy their wheat and milk and meat from the west, where these products are cheaper. Instead they should concentrate on growing high value crops that the west needs and which could fetch them (the farmers of India) a better price. Since the west has a food surplus there is no danger of our running short of food supplies. Thus we could produce say flowers or vegetables and fruits or oilseeds that do not grow in the colder climate of the north and instead buy the wheat and soya from them.

2. The proponents of WTO also deny that there is any danger of the industrialised nations dumping products on the south. Dumping refers to selling off at throw away prices surplus stocks. In the west the producers are subsidized by the state. Dumping not only helps them to get rid of stocks that would otherwise have to rot in their godowns, it also helps

markets can make a quick profit and their profits are not taxable! The small farmers tend to get pauperized more and their land holdings get more fragmented . This lowers agricultural productivity for commercial crops even further.

- The third major consequence is a decline in food security in farming families and in rural communities.

Production for consumption is one of the most important forms of food security in a predominantly agrarian country. Earlier farmers would grow a number of coarse grains and other crops that suited the local climate and which needed little external inputs. Much of this would go for their own consumption. When this is replaced by commercial cash crops the food security of the family and the local communities evaporates. They now have to buy their food in the market and due to the way the market works, what they buy is always far costlier then the price they get for their produce. When in addition the public distribution system is non existent or being wound down the poor are left with no food security at all!

Biodiversity, biotechnologies and patents:

Even more worrying development is the increasing controls over agriculture that the developed world will have following changes in patenting regimes. Traditionally the natural plant varieties from which all food crops have been evolved are mostly in the tropics. These natural plant varieties are needed even today to bring new genetic vigour to food crops as crop varieties tend to lose resistance over repeated cultivation.

Moreover it is now recognized that the innumerable plant and animal varieties of the tropics are essential for the creation of many new drugs and food products and materials. Now as the natural habitats of these life forms get destroyed the industrialized nations try to preserve these forms in what are called gene banks.

Side by side with this these companies are developing new seed varieties that are more productive but which cannot be replicated by the farmer himself as they have been used to doing. Farmers will have to come to the companies to buy seeds for the next crop. Since the gene banks are in the hands of the corporate and rich countries we automatically have to depend on them for seeds! This is yet another route to undermining our food security.

And just in case we get smart and start developing our gene banks and our own seed lines and our own new organic products, the patent laws are altered. Now the right to produce the seed of his choice is not to be left open to all, or even to a free market. No. Only those who hold a patent can produce it. There have been attempts to patent neem. To patent turmeric, to patent basmati so that they can monopolise it. Of course these are so obviously unfair that we have been able to fight the patents even if we had to go to the US and other foreign courts to do so. But the real danger is what lies ahead. As genes surreptitiously taken from here or otherwise are the basis of new seeds, then we will not be able to replicate them or anything based on them even if their natural parents were ours in the first place!

The other danger of this patent regime, is that a few companies can develop a monopoly of knowledge and a monopoly in the generation of knowledge. The entire area of agricultural research and development comes under corporate control. Research will no longer be decided by what farmers need but what can bring maximum profits to agri buisness. This means research on crops like millets or pulses will be less in priority as compared to high value commercial crops. Second, is its impact on the choice of technologies.

Seed varieties that can farmers can easily replicate will lose to terminator gene technologies. Seed varieties that need less chemicals do not become a priority as the pesticide companies and seed manufacturers are the same. The latest danger is from genetically modified crops which are being carelessly introduced without adequate studies on their safety.

Such corporate control of agricultural technology and research is one of the most serious threats to our food security.

Why does the WTO demand such obligations:

If the case against such regulations is so obvious we need to know why they are being imposed on us and why the Indian government has agreed. The reasons are simple.

- There is a tremendous surplus in the western industrialized nations in their main agricultural products wheat, milk products and meat. The huge corporates that control trade need to find fresh markets for this produce.
- Secondly the pattern of consumption in the industrialized countries is such that it needs a large number of products from tropical countries

to maintain their standard of living. Sugar, coffee, tea, cocoa, fruit juices, vegetables and fresh fruits, vegetables, nuts, tobacco, flowers - to name just a few. Moreover as awareness of health and environment increases so does the recognition that synthetic alternatives are no substitute, and are dangerous as compared to their tropical natural equivalents. Thus cotton fabrics or vegetable dyes, fruit juices and natural colours are all back in demand. It suits them to have the Tropical countries produce their requirements while their surplus is exported to us. Now the Tropics can produce almost all the food stuffs and organic material it needs, but the Temperate Zone cannot.

Yet the industrialised nations must work out a system by which our markets are opened to their surplus and our production shifted to their needs. In an equitable world perhaps one could have agreed. But in this world our food security is possible only if we are self reliant in our food production. Also the terms of trade are such that the value of commodities exported by the developing nations continue to be very low while what we import is progressively higher. So to meet our imports payments we have to export more and more goods for less and less. This will not lead to development. It will only deplete the soil and natural resources of the nation. One has only to study the situation in Sub Saharan Africa to understand the truth of this statement. These structural adjustment policies were started in Africa as far back as 1985.After 15 years we can see the state they are in. It should lead us to realise the fate that awaits us down this lane.

Also let us remember it was this need for Indian spices and Indian cotton and other Indian goods that brought the west to our shores. It started as trade but ended in our colonisation and enslavement. Under colonialism our markets were kept open to their manufactured goods but our exports of such goods were kept in check. The colonisers were able to extract raw materials at the cheapest terms and change our agricultural cropping patterns to suit their needs. The indigo plantations are one of the best known examples of this. Such a situation did not lead to our growth. It led to such misery and famines and such huge epidemics that millions of Indians died. Today , though it is covered up by a lot of pretty phrases, the present policies represent a return to market relationships similar to that we faced under colonial rule. That is why we call this neo-colonialism. The danger to our sovereignty and to the lives and health of the people are the same as it was under colonial rule.

A second freedom movement:

In such a context what do we do. By we, one means the peoples movements and organizations that represent the poor and weaker sections of society as well as all groups who hold the interests of the poor as their agenda. We also mean the local communities and local organizations who try to organize for resistance or to cope with the increasing hardships they are facing.

- One immediate agenda is of course to let people understand the causes that lie behind the increasing hardships they are facing. About why agriculture is so non-remunerative and why the farmers are getting pauperized and why hunger and malnutrition is so widespread. And of the threat to food security.

- Another immediate agenda is to build up public opinion for strengthening the public distribution system and increasing its outreach. The PDS should include at least 14 essential commodities with at least 30 kgs of food grain allocation per card per month. Targetting does not help the poor. It is more useful to have comprehensive coverage with decentralization of administration and community participation to ensure that the services are effective. Equally important is to strengthen the ICDS programme and base it on locally produced and processed food.(the current move to introduce corn soya mix -possibly of a genetically modified variety needs to be reversed).

- Another peoples initiative that is possible and has been tried successfully is to set up systems of grain banks from the micro to the national level as a basis of local food security and a community based distribution system.

- Yet another area for people's initiatives is the creation of agricultural cooperatives and group farming and collective wasteland reclamation programmes, that strengthen the organizations of poor farmers, help them cope with the present crisis in agriculture and provides for their food security.

- Build up public opinion for policy changes. This includes a) ban on food exports and use of existing burgeoning stocks for food for work programmes that create public infrastructure. b) Reimposition of quantitative restrictions in all areas where the livelihoods of millions of workers are threatened. c) Contesting the unfair patent laws and

policies on biodiversity and biotechnologies that dominate the international research and development scene.

- But most important is bringir g back food security as the central concern of the planning process.

1. The Alma Ata declaration

The International Conference on Primary Health Care meeting in Alma-Ata this twelfth day of September in the year nineteen hundred and seventy eight, expressing the need for urgent action by all governments all health and development workers and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration.

I. The conference strongly reaffirms that health, which is a state of complete physical mental and social well being and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore of common concern to all countries.

III. Economic and social development, based on New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of the level of health that will permit them to lead a socially

and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms as integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities, and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against the major infectious diseases prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs.

4. includes, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors and demands the coordinated efforts of the those sectors.

5. requires and promotes maximum community and individual self reliance and participation in the planning organization cooperation and control of primary health care, making fullest use of local, national and other available resources and to this end develops through appropriate education the ability of communities to participate.

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all and giving priority to those most in need.

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the country.

VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part should be allotted its proper share.

The International Conference of Primary Health Care calls for urgent and international action to develop and implement primary health

care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF and other international organisation as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

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